AGREEMENT

by and between

EQUITY GROUP - EUFAULA DIVISION, LLC

and the

RETAIL, WHOLESALE AND
DEPARTMENT STORE UNION
AFL-CIO•CLC

EFFECTIVE

March 1, 2004

to

March 1, 2008

EXHIBIT 1

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AGREEMENT

This Agreement made and entered into this 12th day of May, 2004, by and between Equity Group-Eufaula Division, LLC, as to its Baker Hill, Alabama plant located at 57 Melvin Clark Drive, Eufaula, Alabama, 36027 and that plant only (hereinafter referred to as the "Company"), and the Retail, Wholesale and Department Store Union, AFL-CIO, and its Alabama & Mid-South RWDSU Council (hereinafter referred to as the "Union").

ARTICLE 1 - RECOGNITION

1.1 Recognition

A. The Company hereby recognizes the Union as the exclusive bargaining agent for the following employees of the Company: all production employees and line leaders within Company excluding chicken catching crews, truck drivers, office clerical employees, Quality Assurance, HACCP, professional and exempt employees, supervisors, watchmen, guards, nurses, maintenance, refrigeration, contract employees and other employees as defined in the National Labor Relations Act as amended.

ARTICLE 2 - MANAGEMENT RIGHTS

2.1 Reserved

A. The Company reserves all rights to the management and the direction of the workforce, including the right to establish reasonable shop rules and regulations; right to hire new employees from any source, transfer, promote, counsel, warn suspend or discharge for just cause, to retire employees; the right to maintain discipline, assign and reassign employees to jobs; to transfer employees from department to department; to re-classify, upgrade, downgrade to increase and decrease the workforce; to sub-contract work as deemed appropriate; to

schedule work hours and times, schedule breaks, schedule shift start and end times; to determine the days of the workweek; the right to determine job content and create new job classifications, to revise the content of existing jobs and to eliminate part or all of existing job classifications; to determine the product to be handled, produced, or processed; the scheduling of production and the methods, processes, and means of production or handling; and to remove employees from duty because of lack of work by voluntary means then according to seniority standing as herein provided or for other legitimate reasons, is vested exclusively in the Company, except as otherwise provided in this Agreement and provided that such action by the Company will not be used for the purpose of discrimination against any employee or the Union.

2.2 **Discontinue Operations**

A. The Company reserves the unrestricted right to suspend or curtail the operation of the plant and to discontinue processes, products, and departments in whole or in part whenever in its judgment conditions warrant such suspension, curtailment, or discontinuance.

2.3 **Subcontracting**

A. If the Company should subcontract any portion of its business, any displaced employees would be offered a position, by seniority, for which they are qualified.

ARTICLE 3 - SENIORITY

3.1 **Principle**

A. The principles of seniority shall prevail on a plant basis in regard to layoffs, recall, transfer or promotion to bid

positions. In order to qualify for a bid position, the individual must satisfactorily perform the work (a skill equal to the normal standards of proficiency and quality established by other employees who perform the same work) or reach the required performance within ten (10) working days' time. In the event the employee does not satisfactorily perform the work, the employee will be disqualified and the next most senior, qualified person will be assigned. In extreme cases, the Company and a designated union representative may agree in writing to extend this time two (2) or more working days.

B. When qualifications are substantially equal between two (2) or more employees, then seniority shall prevail.

3.2 New Employees

A. Employees with less than ninety (90) calendar days of service shall be considered probationary and may be discharged at the sole discretion of the Company.

3.3 Discharge

A. Employees having more than ninety (90) calendar days of service may be discharged for just cause and such discharge must be by written notice to the employee stating the reason for the discharge. For the purpose of this section, "just cause" shall include but shall not be limited to: dishonesty; intoxication; violation of the Company's drug and alcohol policy; harassment policy or safety policies and procedures; assault; battery; fighting; damage or theft of property or product; and professional gambling.

3.4 Seniority Broken

A. The seniority service record of an employee shall be

broken when the employee:

1. quits, or is discharged for cause

2. fails to return to work within two (2) consecutive working days after notification of recall

3. has been absent for two (2) consecutive working days without notice to the Company

4. has been laid off for a period of six (6) months

5. has accepted a position with another company while on sick leave, layoff, or suspension

6. fails to return to work due to a continuing disability or sickness for a period of six (6) months, with FMLA leave to run concurrently with any such period of disability or sickness to the extent available. Any period of disability or sickness must be supported by Company approved doctor's certificate stating that said employee would be capable of regular full-time work within six (6) months limitation described above. Further, following the expiration of any available FMLA leave, the employee is responsible for the cost of all medical benefits which must be paid to the Company in advance.

3.5 Seniority Lists

A. The Company shall prepare a seniority list of all employees during the months of January and July to which the Union may object within thirty (30) working days. The list, when or if adjusted, shall be final except as to new employees.

ARTICLE 4 - LEAVE OF ABSENCE

4.1 Personal

A. The Company will follow the provision of the Family Medical Leave Act ("FMLA") as amended.

4.2 Union Business

A. A Leave of Absence, not to exceed fourteen (14) working days, will be granted to not more than three (3) employees at a time, without loss of seniority, who have been elected or designated to attend union conventions, schools or seminars.

Company sponsored benefit provisions may not be available through the Company during this period if Union provided benefits are available. In the event benefits remain in force, the employee will be responsible for the total costs of benefits during the leave.

4.3 Applications

A. All requests for leaves of absence must be made in writing and must be accompanied by appropriate supporting papers.

4.4 Extensions

A. All leaves not covered under FMLA may be extended at the Company's discretion.

4.5 Compensation

A. All leaves of absence will be granted without pay.

4.6 Return

A. Employees on leaves in excess of fifteen (15) working days must give at least two (2) working days' notice of their intention to return to work and pass a drug screen upon return. Employees returning from medical leave, leaves defined under the Family Medical Leave Act and leaves specific to workers' compensation must present a doctor's release to the Personnel Department before beginning work.

4.7 Another Job

A. A leave of absence will not be granted for an employee to take another job or to enter business for themselves. Any leave of absence requested or granted under false pretenses shall be grounds for immediate discharge.

4.8 Funeral Leave

A. An employee who suffers the death of a Member of the

Immediate Family shall be granted a leave of absence of up to three (3) working days. These three (3) days will be as follows: One (1) preparation day prior to the funeral; one (1) day for the day of the funeral; and one (1) day within the seven (7) calendar days after the funeral. A non-probationary employee shall receive line time for each scheduled working day missed to attend the funeral but not to exceed twenty-four (24) hours pay at their current rate in effect in the payroll week immediately preceding the week in which the funeral leave falls. The time so paid shall not be counted as hours worked. Proof of the funeral date and relationship will be required.

B. "Members of the Immediate Family" shall mean the persons standing in only the following legitimate relationships to the employee:

1. Mother
2. Father
3. Spouse
4. Child
5. Step-Child
6. Sister
7. Brother
8. Current Step-Parent
9. Grandparent

C. In addition, a non-probationary employee may request up to a total of two additional days off, without pay, to be taken within the 7 days before or after the funeral of a Member of the Immediate Family as defined above subject to the approval of the Company.

D. An employee who suffers the death of their current Mother-in-Law or current Father-in-law may receive eight (8) hours of paid leave of absence for the day of the funeral only. Paid leave shall be at the employee's current rate of pay in

effect in the payroll week immediately preceding the week in which the funeral leave falls.

4.9 Jury Duty

A. Any employee that has to serve on jury duty shall receive paid leave for the hours which the employee otherwise would have worked and shall be reimbursed by the Company for the difference between the jury duty fee and department hours for the time lost from work, up to a maximum of ten (10) working days. The employee shall present proof of the jury service and the fee. If an employee is summoned for jury duty and subsequently released or was not required to serve a full day, the employee shall report immediately for work or be counted as absent and forfeit jury duty reimbursement.

4.10 Military Leave

A. The Company will follow the current Universal Military Training Act.

4.11 Family and Medical Leave Act

A. The Company will follow the current Family and Medical Leave Act as amended.

ARTICLE 5 - JOB VACANCIES

5.1 Temporary Vacancy Defined

A. Temporary vacancies shall be offered first to employees on duty within the department who can perform the work without training and shall be granted to the most senior volunteers. If there are not sufficient volunteers, it shall be assigned to the most junior qualified employee within the department who can perform the work without training.

B. If there is not an available employee within the

department who can perform the work without training, it shall be offered to employees on duty who can perform the work without training and shall be granted to the most senior available volunteers. If there is not sufficient volunteers, it shall be assigned to the most junior available qualified employee on duty who can perform the work without training. In cases where there is not one available who can perform the work without training, then the most junior available qualified employee who can do the work will be assigned. However, in cases of extreme emergency, any employee may be used to avoid loss of production until the above can be implemented in a reasonable time frame.

C. Temporary vacancies to exist for a period of twenty (20) working days or more shall be posted, with the understanding that the successful bidder will remain on the temporary job until the employee returns to work or ceases employment and/or is terminated. If the employee returns to work, the employee on the temporary job will be assigned to available work and have the employee's bidding rights restored.

5.2 **Permanent Vacancy Posted and Defined**

A. A permanent vacancy is a vacancy caused by a quit, discharge, transfer, or promotion of a non-probationary employee, or the establishment of a new premium job. When a permanent vacancy occurs in a premium pay job covered by this Agreement, the Human Resources Department shall post the premium job. The following steps shall be followed:

Step 1: The premium job to be filled will be posted for three (3) working days. During this time, any qualified non-probationary employee may bid for the premium job. Within three

(3) working days, any qualified employee may bid for the premium job by signing their name on the notice, except employees

1. with less than ninety (90) calendar days seniority; or

2. who are unable to meet the trial period because they are not actively working when assigned for the trial period; or

3. who are unable to physically perform the premium job when assigned, provided this clause does not conflict with any state or federal law; or

4. with a suspension in the last six (6) months

Step 2:

1. As soon as possible, but not to exceed fifteen (15) working days from the date of posting, the eligible, qualified senior bidder shall be assigned the premium job subject to the provisions of Article 3.1.

2. A successful bidder shall not be entitled to bid another premium job or shift change for six (6) months unless the employee's premium job has been eliminated within that period, nor shall the employee be entitled to return to employee's old job once it has been filled by another employee.

Step 3:

1. Once the employee has qualified for the employee's newly bid premium job, the employee's old premium job shall be posted in accordance with this Section. An employee, however, will have the option of returning to the employee's old job at any time during the employee's first ten (10) working days on the new premium job.

2. After ten (10) working days, the employee's old premium job will be posted in accordance with this section. In extreme cases, the Company and a designated union representative may agree, in writing, to extend this time two (2) or more working days.

5.3 **Temporary Employees**

A. The Company may use temporary employees provided, however, that no regular employee will be displaced so long as consistent with the terms of this Article.

B. If the Company engages temporary employees, such persons shall be deemed to be employees if they have been continuously engaged by the Company and working on a daily basis for 90 consecutive days. After 90 days of continuous employment, such persons shall be deemed to be probationary employees and subject to all of the terms and conditions of this Agreement.

ARTICLE 6 - STEWARDS AND GRIEVANCE PROCEDURE

6.1 **Shop Stewards**

A. The Union may elect or appoint employees as shop stewards and chief stewards to handle grievances or disputes with the Company's designated representatives on Company time. The Union will keep the Company advised as to the identity of the individual shop stewards and chief stewards in writing. Shop stewards and chief stewards must be employees of the Company in order to represent employees in the grievance procedure.

B. The Company will not pay for time necessary to handle grievances, if handled outside the steward's line time.

6.2 **Grievance Procedure**

A. Should any difference, dispute, or complaint arise over the interpretation or application of this Agreement, there shall be an earnest effort on the part of both parties to settle promptly in accordance with the following procedure.

B. All grievances shall be settled using working days. Working days are defined as Monday through Friday, excluding

contractual holidays.

C. Employees and/or stewards should talk to their immediate supervisor before going to Step 1 of the grievance procedure.

D. Procedure: The following steps shall be followed as to all grievances. Once resolved at any step of this procedure, the grievance may not be refiled on behalf of the employee or the Union.

Step 1: The Employee and/or steward must submit, on the grievance form, the matter to the shift manager within four (4) working days after the occurrence. The shift manager must render a decision within four (4) working days, if not, the grievance automatically moves to Step 2. Any grievance not presented within four (4) working days after the event shall be waived.

Step 2: If a grievance is not settled in Step 1, it shall be presented in writing by the Union steward and/or employee to the plant manager. If the grievance is not presented within three (3) working days after the first step answer, it will be considered null and void. Management must answer in writing within three (3) working days, including a brief reason for any denial of the grievance.

Step 3: If the grievance is not settled in Step 2, the grievance shall be submitted to the Human Resources Manager or designated representative, by submitting a written request to the Human Resources Manager, within five working days of the Step 2 answer. If requested by the Union, the Human Resources Manager or representative shall set up a meeting with the steward filing

the grievance, grievant, if requested by the Union, and the Union business agent to discuss the grievance at a time and place mutually agreeable to the parties within 10 working days of the submission by the Union to Step 3. The Human Resources Manager or representative shall make a written reply to the grievance within five working days following the meeting or submission of the grievance to Step 3 if no meeting is sought by the Union.

Step 4 - Arbitration:

(a) Selection of Arbitrator. If a grievance is not settled in Step 3, it may be submitted to arbitration. The Executive Board for the Union shall have the sole authority to determine whether or not the employee's grievance is qualified to be submitted to arbitration by the Union. The request for arbitration shall be in writing and shall be made to the Company and the Federal Mediation and Conciliation Service (FMCS) within fifteen (15) working days of the Step 3 answer. In the event the Union does not respond in writing within fifteen (15) working days, the grievance shall be considered settled in the Company's favor. After a request has been made by the Union to the Company to submit a case to arbitration, the parties shall promptly meet for the purpose of selecting an arbitrator to hear a pending case. In the event the parties hereto are unable to agree upon the selection of an arbitrator within ten (10) working days after receipt by the Company of a request to submit a case to arbitration, a joint request by the parties hereto shall be made to the FMCS to furnish a suggested list of names of seven (7) arbitrators from which list the parties shall select one (1) arbitrator. Such selection shall be by agreement, if possible,

otherwise the parties alternately eliminate names from said list. The parties shall strike the arbitrator within seven (7) working days upon receipt of the panel. After each party has eliminated the name of three (3) arbitrators from the list, the remaining one shall be accepted by both parties as the arbitrator to hear and decide the pending case.

(b) Arbitration Proceedings. The fee of the Arbitrator, as well as any other arbitration fee, shall be borne equally by the Union and the Company except that the cost of the transcript of the arbitration proceeding, if one is deemed necessary by either party, shall be borne by the party requesting same. The jurisdiction and authority of the Arbitrator and his opinion and award, which shall be final and binding upon the parties, shall be exclusively limited to disputes arising under the express terms of the Agreement. The Arbitrator shall have no power to add to, subtract from, or modify any of the terms of this Agreement. The Arbitrator shall not have the jurisdiction or authority to substitute his or her judgment or discretion for that of management. The Arbitrator shall be limited to rendering an award which is remedial. Any award of back pay by an Arbitrator shall be limited by the amount of wages the employee otherwise would have earned from his employment with the Company during the period involved less any compensation for personal services received from employment elsewhere, or unemployment compensation received, during the period in question. No back pay shall be awarded for any period which the employee would have been laid off. Under no circumstances shall an employee be made more than whole or receive back pay for a period of more than ten

working days prior to the initial filing of the grievance in writing. The Arbitrator shall not have authority to pass upon questions relating to his own jurisdiction and he shall not have authority to be empowered to affect, rule upon, or grant extension or renewal of this Agreement. Neither the violation of any provision of this Agreement nor the commission of any act constituting an unfair labor practice or otherwise made unlawful by any federal, state or local laws shall excuse employees, the Union, or the Company from their obligations under the provisions of this Article.

E. Time is of the essence, and the limits strictly observed by employees, the Union and the Company. The failure of an employee or the Union to process a grievance through any one of the foregoing steps, or to do so in a timely manner, shall prevent the grievance from being considered at a subsequent step. The failure of the Company to respond in a timely manner shall be deemed an approval of the grievance. The time limits specified in this Article only may be modified or extended by written agreement signed by an authorized official of the Company and the Union. No more than one (1) extension shall be granted for any one (1) grievance.

6.3 Cost of Arbitration

A. The expense of the arbitrator shall be split equally by the parties and the costs of the panel shall be paid by the requesting party.

6.4 Executive Board Authority

A. At any step in the grievance procedure, the Executive Board of the Local Union shall have the final authority, in

respect to any aggrieved employee covered by this Agreement, to decline to process a grievance, complaint, difficulty, or dispute further if in the judgment of the Executive Board such grievance lacks merit or lacks justification under the terms of this Agreement to the satisfaction of the Executive Board.

6.5 Presence of Stewards

A. An employee may request that a steward is present in any disciplinary action being administered to him and such request will be honored. The steward must be an employee of the Company.

ARTICLE 7 - BULLETIN BOARDS

7.1 Posting

A. The Company shall provide the Union with a bulletin board for the posting of official Union notices. Such notices will be shown to the Plant Manager before posting. The Company and the Union agree that neither party will post political material within the plant.

ARTICLE 8 - UNION VISITS

8.1 Union Representation

A. The Company shall admit to its premises two (2) union representatives who are employed by the Retail, Wholesale and Department Store Union, AFL-CIO, and its Alabama & Mid-South RWDSU Council, at any one time, who may visit inside the plant at reasonable hours. Notice of a visit shall require three (3) working days notice, in writing, to the Company. The Union shall notify the Company in writing who the representatives are by name and position with the Union. Changes in union representatives shall require three (3) working days' written notice to the

Company. Such visits shall not interfere with the Company's operation and shall be for the express purpose of contract administration and grievance investigation. Union officials shall not go into production areas of the plant without permission of management, which reserves the right to accompany Union officials. The Company and the Union agree that neither will hand out political material on Company premises.

ARTICLE 9 - SAFETY AND HEALTH

9.1 Occupational Safety and Health Act

A. The Company affirms its intention of complying with the provisions of the Occupational Safety and Health Act, and the Union agrees that it will support management in its efforts at compliance and general improvements of safety conditions. The Union further agrees to encourage its members to work safely and to follow the instructions of the Company in the proper care, use operation, protection, and maintenance of property, equipment, and vehicles.

9.2 Accidents, Injuries

A. It shall be the responsibility of each individual employee to notify the employee's superior immediately of any accidents, injuries or defective equipment. An employee who is injured during working hours, while performing the employee's assigned work and who is physically unable to return to work on the shift as determined by medical opinion, shall be paid for the remainder of the employee's normal work shift for that day at the employee's regular basic hourly rate in an amount not to exceed eight (8) hours. Employees required by the doctor to return for further treatment of an on-the-job injury shall endeavor to make

all doctors' appointments during non-working hours.

9.3 Joint Safety Committee

A. The Company and the Union shall establish a Joint Safety Committee consisting of two members appointed by the Company and two members appointed by the Union. The function of the Joint Safety Committee shall be to review all safety regulations, and to promote health and safety education of the employees and to meet monthly on definitely established dates for the purpose of considering safety issues, inspecting the facilities as may be necessary and recommending measures for the elimination or control of conditions which may be unsafe or hazardous to the health and safety of other employees. The Joint Safety Committee shall not discuss general grievances or otherwise consider disciplinary issues, nor shall it adopt rules or procedures. This provision does not modify the Management Rights set forth in Article 2.

ARTICLE 10 - HOLIDAYS

10.1 Holidays Defined

A. All employees having established seniority shall receive eight (8) hours' pay at their regular rate of pay for the following holidays:

New Year's Day
Martin Luther King Day
Memorial Day
Fourth of July
Labor Day
Thanksgiving Day
Christmas Eve Day
Christmas Day
Birthday Holiday

10.2 Celebration

A. Holidays falling on Saturday will be observed on the preceding Friday, holidays falling on Sunday will be observed on Monday.

After one (1) year's seniority - one (1) week

After three (3) year's seniority - two (2) weeks

After ten (10) year's seniority - three (3) weeks

11.2 Vacation Pay

A. At the beginning of their vacations, and only with two (2) weeks written notification prior to the first day of vacation time being requested, employees who have completed their first anniversary shall receive forty (40) hours of pay at their regular rate of pay, provided the employee has worked sixteen-hundred (1600) or more hours in the past anniversary year.

11.3 Vacation Period

A. By December 1 of each year, plant management will distribute to all employees a vacation preference form on which each employee will indicate the employee's first, second and third choices. Prior to January 1, a vacation schedule will be posted. Preferences will be granted upon the basis of seniority, but in all cases the Company has the exclusive right to schedule, reschedule or postpone vacations based on business necessity. Once vacations are scheduled after January 1, no employee may bump another employee from their selected vacation slot. Employees having more than one (1) week earned vacation may take them on a staggered basis throughout the year. Vacation may be split by weeks. An employee may take up to ten (10) working days' vacation per year one (1) day at a time, provided that the employee requests approval from the employee's supervisor at least two (2) weeks in advance. An employee requesting a one (1) day vacation on Friday will be required to work on Saturday following the one (1) day vacation, unless the one (1) day

vacation request has been made prior to the posting of weekend work.

ARTICLE 12 - HOURS OF WORK

12.1 Work Schedule

A. Work schedules for employees will vary in the Company. Operational demands may necessitate variations in starting and ending times, as well as variations in the total hours that may be scheduled each workday and workweek.

12.2 Overtime Pay

A. Employees will be paid overtime pay at the rate of one and one half (1-1/2) times their regular rate of pay for hours actually worked in excess of forty (40) hours per week.

12.3 Reporting Pay

A. All employees who report for work at the commencement of a scheduled shift without having been given reasonable notice of a change in schedule shall be given a minimum of four (4) hours' work, except in cases where work cannot be provided due to circumstances beyond the Company's control.

12.4 Time Cards

A. Each employee will scan in the employee's own time card immediately before the commencement of the work period and immediately at the end of the work period.

12.5 Line Time

A. All employees will be paid according to the hours of work indicated by the Master Line Time Card.

12.6 Extra Time

A. Employees designated by their supervisor or superintendent to work beyond their scheduled time shall be

governed by their individual time card reports, which will be approved by management.

ARTICLE 13 - MISCELLANEOUS

13.1 Physical Examination

A. The Company will follow all applicable State, Federal and local laws for physical exams and drug screening as they relate to hiring, promotions, transfers, job assignments, near accidents, accidents and property damage.

13.2 Meal/Rest Periods

A. Employees will receive two (2) thirty (30) minute non-paid meal/rest breaks each full work day. In addition, where an employee is required to work more than 9 hours in any workday, except in the case of equipment or mechanical malfunctions or circumstances beyond the control of the Company, the employee shall be entitled to an additional 10 minute paid break to be scheduled by the Company, or to be paid for such break if not granted.

13.3 Anti-Discrimination

A. The Company and Union agree each will comply with all Federal, State and Local anti-discrimination laws.

13.4 Supplies

A. Supplies will be furnished to new employees, where required, in accordance with Company procedures as follows:

-Smocks (3)
-Arm Guards
-Cutting Glove
-Hair Net
-Beard Net
-Blue Gloves
-Cotton Gloves
-Ear Plugs
-Apron - heavy duty
-Sleeves

B. Arm guards and cutting gloves are not provided to new employees assigned to Packout, Live Hang, Shipping and Sanitation.

C. Employees are entitled to receive, on a weekly basis, Blue Gloves (cotton liners in Shipping), Hair Nets and Beard Nets.

D. In addition, employees are entitled to receive, on the first Monday of each month, sleeves and ear plugs; and shall be entitled to receive one new smock and a heavy duty apron every 6 months as of January 1 and July 1 of each calendar year. The employee must turn in one smock in order to receive a new one without charge. If the plant is not operating on a scheduled replacement day, the replacement clothing will be distributed on the next work day that the plant is operating.

E. Employees who are required by the Company to wear boots will be provided boots at that time and may obtain replacement boots as needed in the determination of the Company, provided, however, that the employee turns in the original boots.

F. Except as noted, employees must purchase replacement supplies from the Company.

G. The Plant Manager shall approve these supply procedures. The Company reserves all rights to revise these procedures as necessary.

13.5 Discipline

A. If an employee has not violated any Work Rules or General Safety Rules or incurred any discipline pursuant to the general progressive disciplinary system within 24 months, the last level of discipline shall be reduced to the next lower level

of discipline and not be considered in future discipline under the Work Rules, General Safety Rules or general progressive disciplinary system. Any remaining disciplinary levels shall be deemed reduced to the last lower level, one level at a time, if the employee does not violate any Work Rule or general safety Rule or incur any discipline under the general progressive disciplinary system every subsequent 12 months. This provision does not modify the application of the Work Rules or the General Safety Rules or the applicable discipline which may be assessed for any violation, including the right to increase the disciplinary level depending on the severity of the violation or the employee's disciplinary history which is subject to consideration.

13.6 Orientation

A. The Union shall be permitted to have a representative selected by the Union to address new employees at any formal orientation session. If no Orientation is held, the Union representative shall have the opportunity to meet with each such new employee at least one week prior to the completion of the employee's probationary period.

ARTICLE 14 - WAGES

14.1 Schedule A

A. The Company shall pay its employees the amount of wages for the various classification set out in Schedule A attached hereto and made a part hereof.

14.2 Pay Day

A. Checks will be distributed at the end of the shift on Friday unless changed by the Company.

14.3 Incentive Pay

A. The Company reserves the right to establish, modify, add, or delete incentive programs, as they deem appropriate, as long as the change does not violate the provisions of Schedule A.

ARTICLE 15 - NO STRIKE - NO LOCKOUT

15.1 Prohibited Conduct

A. During the whole period this Agreement is in effect, the Company shall not lock out its employees and the Union shall not authorize or sanction any strike, stoppage, slowdown, or suspension of work against the Company.

ARTICLE 16 - CHECK-OFF

16.1 Collection of Dues and Remittance

A. The Company shall, for the term of this Agreement, deduct initiation fees as authorized and shall deduct union dues, arrears, assessments and/or fees in an amount certified by the Union from the weekly wages of employees covered by this Agreement who individually and voluntarily certify in writing authorization for such deduction, until revoked pursuant to the terms of the Check-Off Authorization set forth in Article 16.2. The Company shall promptly remit all sums deducted in this manner to the Secretary-Treasurer of Local union not later than the 15th of the next month. The check off, however, is to apply only to such employees covered by this Agreement who authorize the Company in writing to so check-off. The Union agrees to defend and hold the Company harmless against expenses, repayment, or losses for any demands, claims, disputes, or lawsuits by an employee arising in any manner out of or in connection with the check-off of any amount claimed by the Union to be due it or

having been paid it by or for any employee.

B. The wording of this labor contract shall supercede and take precedence over all other language on the check-off/authorization card.

16.2 Check-Off Authorization Form

A. The Company shall not deduct any monies from an employee's wages pursuant to Article 16.1 unless the Check-Off Authorization card executed by the employee conforms to the following form:

CHECK-OFF AUTHORIZATION

I, the undersigned employee of Equity Group-Eufaula Division, LLC (hereinafter referred to as the "Company") of my own free will and accord hereby authorize and direct the Company to deduct weekly ( ), monthly ( ), from my earnings the amount owed by me for membership dues to the Retail, Wholesale and Department Store Union, AFL-CIO, Alabama & Mid-South RWDSU Council, AFL-CIO (herein referred to as the "Union") irrespective of my membership in the Union and to transmit such amount to the Union no later than the end of the month following the month in which the deductions are made. As of the date of this authorization, such dues are $ weekly ( ), bi-weekly ( ), monthly ( ). However, the amount of membership dues may be changed pursuant to the provisions of the Constitution of the parent body of the Union namely, the Retail, Wholesale and Department Store Union, AFL-CIO, and in the event the Union shall notify the Company in writing of the amount of the dues as so changed and upon receipt of such notification, the Company is hereby authorized to deduct from my earnings the amount of the dues as so changed.

If for any reason I should become delinquent in the payment of my membership dues to the Union, I hereby further authorize and direct the Company to deduct, each pay period, from my earnings the amount of delinquent dues, as reported to the Company by the Union and in the amount reported to the Company by the Union until the total amount of delinquent dues is paid in full.

I hereby agree that neither the Company nor the Union shall be under any liability to me for the deduction of dues from my earnings in the manner described and set forth above and that maintaining my

continuous good standing in the Union is my personal responsibility.

I reserve the right to revoke this authorization by giving individual written notice by registered-certified mail to the Company and to the Union either during ten (10) days immediately preceding any anniversary of the date shown below or during the ten (10) days immediately preceding the termination date of any collective bargaining agreement between the Company and the Union (whichever occurs sooner) which is applicable to me as an employee of the Company and unless or until revoked in the above stated manner, this authorization shall continue in full force and effect.

Dues and fees are not tax deductible as charitable contributions but may be tax deductible as business expense.

Print Name _____ Soc.Sec.No._____

Signature of employee_____

Address_____

_____ Date _____

ARTICLE 17 - BENEFITS

17.1 Employee Coverage

Coverage for single employees will be provided as follows through Blue Cross Blue Shield of Alabama Low Option PPO, or its equivalent:

A. Effective June 1, 2004, those employees completing their probationary period will be eligible for single employee coverage as provided in Blue Cross Blue Shield of Alabama Low Option PPO, or its equivalent. Single employee coverage costs, including increases, will be paid by the Company, with the additional costs for spousal, dependent and family costs and increases to be paid by the employee. Pending the effective date of such coverage, the present medical coverage will be continued.

B. Employees completing 12 months of employment will be

eligible for the benefits described in Section 17.1.A plus $125.00 per week accident and sickness benefits payable after 15 days of accident or illness for a period of 13 weeks as set forth in the applicable insurance plan, to be paid for by the Company.

17.2 Dependent Coverage

A. Employees may elect dependent coverage, and if so shall be responsible for payment of the applicable premium. This coverage will be as set forth in Blue Cross Blue Shield of Alabama Low Option PPO, or its equivalent.

17.3 Substitution of Coverage

A. So long as coverage and service levels are maintained without material change, the Company may alter insurance providers or administrators with prior notification to and opportunity for discussion with the Union.

ARTICLE 18 - SAVINGS CLAUSE

18.1 Good Faith

A. The Company and the Union each acknowledge that this Agreement has been reached as a result of good faith collective bargaining by both parties hereto and it contains the entire understanding between the parties and is to be strictly construed.

18.2 Separability

A. In the event any provision of this Agreement is held to be in conflict with or violation of any state or federal statute or other applicable law, administrative rule or regulation, such decision shall not affect the validity of the remaining provisions of the Agreement. The parties further agree that they will meet within thirty (30) days to renegotiate the provision or

provisions of this Agreement held to be invalid.

ARTICLE 19 - LENGTH OF AGREEMENT

19.1 Duration

A. This Agreement shall become effective the 12th day of May, 2004 and shall remain in full force and effect until the 1st day of March, 2008, and shall remain in full force and effect for one (1) additional year thereafter unless terminated by either party by written notice to the other at least sixty (60) days prior to the 1st day of March, 2008.

THE RETAIL AND WHOLESALE DEPARTMENT STORE UNION, SOUTHEAST COUNCIL, DISTRICT COUNCIL OF THE UFCW, AFL-CIO-CLC

Henry Jenkins, International Vice President

Jerry Foster, Representative

Jacqueline Davis

Barbara Green

Kelvin Granger

Shekina Freeman

Joanne Bussey

EQUITY GROUP - EUFAULA DIVISION, LLC

Spence Jarnagin, General Manager

James Davis, Human Resources Director

Greg Mills, Plant Manager

SCHEDULE A

Section 1 - Pay Scales and Job Classifications

The following minimum base rates, effective as of the payroll week following the effective date, for all employees covered by this Agreement is as follows:

Effective Date	3/01/04	3/01/05	3/01/06	3/01/07
Hire Rate	7.00	7.10	7.20	7.30
90 Calendar Days	7.25	7.35	7.55	7.75
1 Year	8.00	8.25	8.50	8.85

Section 2 - Premium Jobs

A. Effective as of the ratification of the Agreement, the following hourly premiums will be paid on these classifications after 90 calendar days:

Processing Plant

1.	Knife Sharpener	25¢
2.	Chiller Operator	25¢
3.	Wash Station	25¢
4.	Truck Spotter	50¢
5.	Lift Driver	50¢
6.	Fork Lift Operator	50¢
7.	Pallet Jack Operator	50¢
8.	Back-up Killer	50¢
9.	USDA Insp/Helper	50¢
10.	Mirror Trimmer	50¢
11.	On-line Production Employees Using Knives and Scissors	50¢
12.	Line Puller in Freezer	50¢
13.	Line Leaders	70¢
14.	Live Hanger	$1.00

B. Effective beginning in the second year of the Agreement, the premium to be paid to Line Leaders shall be increased by 15¢ to 85¢.

Section 3 - Starting/Probationary Rate

The starting rates for new or rehires will be the rate shown in Section 1 of Schedule A. Employees completing the probationary period will receive the applicable increase.

Section 4 - Regular Rate Defined

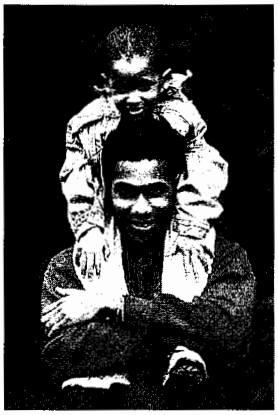
The regular rate of pay for computing vacation and holiday pay will consist of the employee's base rate plus any skill premium they receive.

Section 5 - Shift Pay Differential

A premium of ten cents (10¢) per hour will be paid when a majority of the scheduled hours are worked on the 2nd or 3rd shift. Effective beginning in the second year of the Agreement, the Shift Pay Differential premium shall be increased by 5¢ to 15¢ per hour.

Section 6 - Eligibility for Premium Pay: In order to qualify for premium pay the employee must:

1. have completed 90 calendar days with the Company
2. meet the production, skill and quality requirements of the premiums pay position
3. work three (3) hours or more in the premium pay position during the workday



Group Health Care Plan

Equity Group Eufaula Division, LLC

Low Option PPO Hourly Employees

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Effective January 1, 2007

EXHIBIT 2

WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you we will provide the best service we can in the administration of your group health plan. The following information summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits. There are sections explaining eligibility and defining certain words, too. Please be sure to read this information in its entirety. This information is a "summary plan description" or "plan" as defined by ERISA, the **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974 as amended.

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of **independent** Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

If you have any questions which the person in your company who deals with employee benefits cannot answer, please contact the Blue Cross and Blue Shield of Alabama Customer Service Department.

Attention Please This booklet contains a summary in English of your plan rights and benefits. If you have difficulty understanding any part of this booklet, contact Blue Cross and Blue Shield of Alabama's Customer Service Department at 1-800-292-8868 *(or the group's dedicated Customer Service number)*. Office hours for Customer Service are from 8:00 a.m. to 5:00 p.m. Monday through Friday, CST (Central Standard Time). You may also contact your plan administrator or employer's benefit office for more information.

Atención por favor - SpanishEste folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-800-292-8868. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Group Number 11823/008

TABLE OF CONTENTS

SUMMARY OF HEALTH BENEFITS

This table is a summary of benefits and is subject to all other terms and conditions of the Plan:

To maximize your benefits seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1-800-810-BLUE (2583) or access our website at www.bcbsal.org to find out if your provider is a PPO member.

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in paragraph 5. of "Benefit Conditions."

INPATIENT HOSPITAL		
Benefit	**PPO**	**Non-PPO**
Coverage	365 days of care during each confinement*; $200 deductible per admission**; covered inpatient expenses paid at 100% of the PPO Allowance	365 days of care during each confinement*; 80% of the Allowed Amount, subject to the calendar year deductible
Preadmission Certification	Required for all admissions except maternity; emergency admissions require notification within 48 hours of admission; **for precertification call 1-800-248-2342 toll-free**	
Inpatient Mental and Nervous/Substance Abuse	100% of the PPO Allowance, subject to the inpatient deductible**; limited to 30 days each 12 consecutive months*	80% of the Allowed Amount, subject to the calendar year deductible**; limited to 30 days each 12 consecutive months*

* If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; inpatient hospital days are limited to a combined PPO and Non-PPO maximum of 365 days for each confinement; mental and nervous disorders (including substance abuse) are limited to a combined PPO and Non-PPO maximum of 30 days; no coverage is available for mental and nervous disorders under Other Covered Services after the 30 days are used.

** The deductible is due for each admission or readmission; however, only one deductible is due per pregnancy, during transfers from one hospital to another, or when two or more family members are admitted as inpatients as a result of injuries received in one accident.

OUTPATIENT HOSPITAL *		
Benefit	**PPO**	**Non-PPO**
Accidental Injury	100% of the PPO Allowance, no deductible or copay applicable	100% of the Allowed Amount when services are rendered within 72 hours of the accident; after 72 hours, 80% of the Allowed Amount, subject to the calendar year deductible
Surgery and Medical Emergencies	100% of the PPO Allowance, subject to a $50 facility copay	80% of the Allowed Amount, subject to the calendar year deductible
Diagnostic Lab and X-ray, IV Therapy, Radiation Therapy and Chemotherapy	100% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible

* Outpatient hospital services will be processed as Other Covered Services rather than as Outpatient Hospital Benefits if (1) the facility bills for an emergency room visit but the patient's condition does not meet the definition of a medical emergency (this includes any lab and x-ray exams, diagnostic tests and other services or supplies associated with the emergency room fee), or (2) the services or supplies you receive are not listed in the table above.

PREFERRED HOME HEALTH AND HOSPICE BENEFITS*		
Benefit	**PPO**	**Non-PPO**
Preferred Home Health and Hospice Care Within the State of Alabama	100% of the PPO Allowance, no deductible	Not covered
Preferred Home Health and Hospice Care Outside the State of Alabama	100% of the PPO Allowance, no deductible; **precertification is required - call 1-800-821-7231**	80% of the PPO Allowance, subject to the calendar year deductible; the remaining percentage applies toward the annual out-of-pocket maximum; **precertification is required - call 1-800-821-7231**

* Any covered expenses for Preferred Home Health Care and covered Non-PPO expenses for Preferred Hospice Care apply toward the lifetime maximum.

PHYSICIAN SERVICES		
Benefit	**PPO**	**Non-PPO**
Surgery and Anesthesia, In-Hospital Visits, Second Surgical Opinions and Inpatient Consultations	100% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Diagnostic X-Rays and Lab Exams	100% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Office Care Services, Emergency Room Services and Outpatient Consultations	100% of the PPO Allowance, subject to the $25 office copayment	80% of the Allowed Amount, subject to the calendar year deductible

PREVENTIVE CARE SERVICES		
Benefit	**PPO**	**Non-PPO**
In-Hospital Routine Newborn Care	100% of the PPO Allowance, no deductible or copayment	Not covered
Routine Well Child Care	100% of the PPO Allowance, subject to the $25 copayment; includes coverage for nine visits during the first two years and one visit per year thereafter through age six	Not covered
Routine Immunizations **(see www.bcbsal.com/immuniza-tions for a listing of specific immunizations)**	100% of the PPO Allowance, no deductible or copayment	Not covered
Routine Pap Smears	100% of the PPO Allowance with no deductible; limited to one per year for females	Not covered

PREVENTIVE CARE SERVICES - Continued		
Benefit	**PPO**	**Non-PPO**
Routine Mammogram **One exam for females ages 35-39 and one per year for females ages 40 and over** **See Mastectomy and Mammograms (later in this booklet) for additional information**	100% of the PPO Allowance with no deductible	Not covered
Routine Prostate Specific Antigen	100% of the PPO Allowance; limited to one exam per year for males ages 40 and over	Not covered
Colorectal Cancer Screening – Ages 50 and Over **Fecal occult blood test (FOBT) once per calendar year;** **Flexible sigmoidoscopy once every three calendar years;** **Double-contrast barium enema once every five calendar years;** **Colonoscopy once every 10 calendar years** **See Colorectal Cancer Screenings (later in this booklet) for additional information**	100% of the PPO Allowance; no deductible Note: Claims for facility charges will be processed under your Outpatient Hospital Benefits and subject to any applicable outpatient copayments	Not covered

NON-PPO PHYSICIAN BENEFITS IN ALABAMA	
Benefits	
Emergency Room Care **Office Visit and Outpatient Consultations** **Surgery and Assistant Surgery** **Anesthesia** **Laboratory and Pathology** **X-rays** **Chemotherapy and Radiation Therapy** **Second Surgical Opinion** **In-Hospital Medical Care** **In-Hospital Consultation**	50% of the PPO Fee Schedule subject to the $200 calendar year deductible

GENERAL PROVISIONS	
Calendar Year Deductible	$200 per person per calendar year; $600 per family*
Annual Out-of-Pocket Maximum	$1,000 per person ($3,000 per family) (applicable to Other Covered Services) plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	$1,000,000 lifetime maximum for each covered member; applies only to Other Covered Services, Non-PPO Outpatient Hospital Services, Non-PPO Physician Services, Mental Health and Substance Abuse Physician Services unless otherwise stated***

* Only one deductible is required when two or more family members have expenses resulting from injuries received in one accident. The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are non-refundable.

** Non-covered expenses and expenses for outpatient Mental Health and Substance Abuse do not apply toward the Annual Out-of-Pocket Maximum.

*** Expenses for accidental injury rendered within 72 hours of the accident in the outpatient department of a Non-PPO facility do not apply toward the Lifetime Maximum.

OTHER COVERED SERVICES	
Benefit*	
Durable Medical Equipment (DME)**	**Preferred DME Supplier in Alabama:** 80% of the Preferred DME Supplier Fee Schedule; subject to the calendar year deductible **Non-Preferred DME Supplier in Alabama:** 80% of the Allowed Amount; subject to the calendar year deductible **DME Supplier Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state; subject to the calendar year deductible

OTHER COVERED SERVICES - Continued	
Benefit*	
Physical Therapy**	**Preferred Physical Therapist in Alabama:** 80% of the Preferred Physical Therapist Fee Schedule; subject to the calendar year deductible **Non-Preferred Physical Therapist in Alabama:** 80% of the Allowed Amount; subject to the calendar year deductible **Physical Therapist Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state; subject to the calendar year deductible
Ambulance Service	80% of the Allowed Amount, subject to the calendar year deductible
Outpatient Mental and Nervous/Substance Abuse	50% of the Allowed Amount, subject to the calendar year deductible; limited to 20 visits per person each calendar year
Inpatient Mental and Nervous/Substance Abuse	80% of the Allowed Amount, not subject to the calendar year deductible
Chiropractic Services	**Participating Chiropractors**- 80% of the chiropractic fee schedule **Non-Participating Chiropractors**- 50% of the chiropractic fee schedule Chiropractic services are subject to the deductible
Occupational Therapy Services for the Hand and/or Treatment of Lymphedema**	**Preferred Occupational Therapist in Alabama:** 80% of the Preferred Occupational Therapist Fee Schedule; subject to the calendar year deductible **Non-Preferred Occupational Therapist in Alabama:** 80% of the Allowed Amount; subject to the calendar year deductible **Occupational Therapist Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state; subject to the calendar year deductible
Allergy Testing and Treatment	80% of the Allowed Amount, subject to the calendar year deductible

* See Other Covered Services in the Health Benefits section for additional services. Most Other Covered Services are paid at 80% of the Allowed Amount after the calendar year deductible is met.

** When using a Preferred or Participating Provider, the provider will bill us and we will pay him or her directly. If you see a Non-Preferred or Non-Participating Provider, you may have to file your claim and you will be responsible for charges in excess of the Allowed Amount.

PRESCRIPTION DRUGS*	
Benefit	
Prescription Drug Program	$10 copay for generic; $20 copay for Preferred brand; $35 copay for Non-Preferred brand; no benefits are available for drugs purchased at a Non-Participating Pharmacy; Participating Pharmacies should have a list of generic, Preferred, and Non-Preferred brands * See Prescription Drug Benefits for a listing of the diabetic supplies included

INDIVIDUAL CASE MANAGEMENT	
Benefit	
Individual Case Management	Services available through Comprehensive Managed Care; see the Individual Case Management section for details

ELIGIBILITY AND PRE-EXISTING CONDITION EXCLUSION PERIODS

Who Is Eligible for This Plan?

You are eligible to enroll in this plan if all of the following requirements are satisfied:

1. you are an employee of your employer and are treated as an employee (as opposed to an independent contractor) by your employer;
2. you work 40 or more hours per week (including vacation and certain leaves of absence that are discussed in the section below dealing with termination of coverage);
3. you are in a category or classification of employees that is covered by the plan;
4. you meet any other eligibility or participation rules established by us or your employer; and,
5. you satisfy any applicable waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

Is There a Waiting Period Under the Plan?

There is a waiting period under the plan. This means that you may enroll in the plan after a specified number of days of continuous employment. Please contact your group administrator to determine the number of days applicable to you. If you are a new employee, the waiting period begins to run on the first day that you report to active duty. Thereafter, days of employment include days during which you are unable to report to work because of an illness or injury. Coverage will begin on the date specified below under "When Does Coverage Begin?" Coverage may also be subject to a pre-existing condition exclusion. See the section below called "Will I be Subject to a Pre-Existing Condition Exclusion Period?"

How Do I Apply for the Plan?

Fill out an application form completely and give it to your employer or group. You must name all eligible dependents to be covered on the application. Your employer or group will collect all of the employees' applications and send them to us.

Which of My Dependents Is Eligible?

Your eligible dependents are:

1. your spouse (of the opposite sex);
2. an unmarried child under age 19;
3. an unmarried child age 19 to 25 while a full-time student in a state accredited school, not working full-time and chiefly depending on you for support; and,
4. an incapacitated child who is not able to support himself and who depends on you for support, if the incapacity occurred before age 19 (or 25 if a "full-time student").

The child may be:

1. a natural child;
2. a stepchild residing in the household of the eligible employee;

3. a legally adopted child;

4. a child placed for adoption; or,

5. any other unmarried child for whom the employee has permanent legal custody and who depends solely on the employee for support and regularly and permanently resides with the employee in a parent-child relationship.

A grandchild is only eligible if he or she meets all of the following guidelines: (1) under 19 years of age; (2) unmarried; (3) chiefly dependent on the employee for support; (4) resides in the same household full-time with the employee in a parent-child relationship; and (5) is not employed on a regular full-time basis. The grandchild's parent may not be covered by the employee's contract unless the grandchild has been adopted by the grandparents and the parent meets all of the other conditions to be covered as a dependent. A grandchild may continue coverage under the plan up to age 25 if unmarried and a full-time student in a state accredited school, not working full time, and chiefly dependent upon the employee for support.

When Does Coverage Begin?

Regular Enrollment:

If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable waiting periods), your coverage will begin as of the date thereafter specified by your group (generally the first day of the month after you have met the eligibility requirements and applied). If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty. An employee who enrolls under this paragraph is called a "regular enrollee."

Late Enrollment:

You may also enroll as a "late enrollee" during your group's annual open enrollment period. Your coverage will begin on the date specified by your group following your enrollment. A late enrollee is any member who doesn't enroll during the regular enrollment period described above or during a special enrollment period. Late enrollees are subject to longer pre-existing condition exclusion periods than regular and special enrollees. See the discussion below on pre-existing condition exclusions for more information about this.

Special Enrollment Period for Individuals Losing Other Coverage:

An employee or dependent (1) who doesn't enroll during the first 30 days of eligibility because the employee or dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or coverage by other health plans which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective as of the date on which the other coverage ended. A member who enrolls under this paragraph is called a "special enrollee."

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for cause (for example, making a fraudulent claim or intentional misrepresentation of a material fact).

Special Enrollment Period for Newly Acquired Dependents:

If you have a new dependent as a result of marriage, birth, placement for adoption, or adoption, you may enroll yourself and/or your spouse and your new dependent as special enrollees provided that you request enrollment within 30 days of the event. The effective date of coverage will be the date of marriage, birth, placement for adoption, or adoption. A member who enrolls under this paragraph is also called a "special enrollee."

If we accept your application, you will receive an identification card. If we decline your application, all the law requires us to do is refund any fees paid.

Will I be Subject to a Pre-Existing Condition Exclusion Period?

Yes, unless you have enough prior creditable coverage to completely eliminate the plan's pre-existing condition waiting period.

In General:

As a general rule, for the first 12 months (365 days) after your "enrollment date" (as defined below), there are no benefits for pre-existing conditions. If you are a late enrollee, there are no benefits for the first 18 months (546 days) after your enrollment date for pre-existing conditions. If you are a regular enrollee, your enrollment date is the earlier of the first day of any waiting period or the first day on which you become covered. If you are a special or late enrollee, your enrollment date is the first day on which you become covered.

The 12 or 18-month pre-existing condition exclusion periods are reduced by any credit you receive for prior creditable coverage (as described below).

A pre-existing condition is any condition, no matter how caused, for which you received medical advice, a diagnosis, or care, or for which treatment was recommended or received during the six-month period preceding your enrollment date. Even if your condition is not diagnosed until after your enrollment date, we will treat your condition as pre-existing if treatment was recommended or received during the six-month period preceding your enrollment date for symptoms that are consistent with the presence of your condition.

Pre-existing conditions do not apply to newborns enrolled within 30 days of birth or children under age 18 who are enrolled within 30 days of the date of adoption or placement for adoption. Pre-existing conditions do not apply to pregnancy.

Credit for Prior Creditable Coverage:

If you were covered by another plan before becoming covered by this plan, we'll credit the time toward the 12 (365 days) or 18 (546 days) month pre-existing conditions exclusion period, if:

a. there is no greater than a 63-day break in coverage, and

b. the last coverage was "creditable coverage," i.e., under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, Champus, Federal Employee Program, Indian Health Service, Peace Corps Service, a State risk pool or a public health service.

If necessary, we will assist in obtaining a certificate from any prior employer, insurer, or Health Maintenance Organization (HMO).

Will The Plan Cover A Child If Required To Do So By Court Order?

If the employer (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, the employer will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The employer has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the employer at the address shown near the end of this summary.

The plan will cover an employee's child if required to do so by a QMCSO. If the employer determines that an order is a QMCSO, Blue Cross will enroll the child for coverage effective as of a date specified by the employer, but not earlier than the later of the following:

1. If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the employer to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.

2. If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the employer to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the employer may increase the employee's payroll deductions. During the period the child is covered under the plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law. For example, a child covered by a QMCSO may be subject to a pre-existing condition exclusion.

While the QMCSO is in effect Blue Cross will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. Blue Cross will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. Blue Cross will also send claims reports directly to the child's custodial parent or legal guardian.

If I Work after Age 65 or Become Eligible for Medicare, Am I Still Covered?

In determining the number of employees of an employer for purposes of the following provisions, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan.

Employers With 20 or More Employees

If your employer employs 20 or more employees and if you continue to be actively employed when you are age 65 or older, you and your spouse will continue to be covered for the same benefits available to employees under age 65. In this case, your group benefits plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare eligible expenses, if any, not paid by the group benefits plan.

If both you and your spouse are over age 65, you may elect to disenroll completely from the plan and purchase a Medicare Supplement contract. This means that you will have no benefits under the plan. In addition, the employer is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

If you are age 65 or older, considering retirement, and think you may need to buy COBRA coverage after you retire, you should read the section below dealing with COBRA coverage - particularly the discussion under the heading "I Am Age 65 or Older and about to Retire. Can I Have Medicare and COBRA Coverage at the Same Time?"

Other Medicare Rules

Disabled Individuals: If you or your spouse is eligible for Medicare due to disability and is also covered under the plan by virtue of your current employment status with the employer, Medicare will be considered the primary payer (and the plan will be secondary) if your group employs fewer than 100 employees. If your group employs 100 or more employees, the plan will be primary and Medicare will be secondary.

End-Stage Renal Disease: If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility (regardless of the size of the employer). Thereafter, Medicare will be primary and the plan will be secondary.

If you have any questions about coordination of your coverage with Medicare, please contact your group administrator for further information.

When Will Coverage Terminate?

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

1. the date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the leave of absence rules below);
2. for spouses, the date of divorce or other termination of marriage;
3. for children, the date a child ceases to be a dependent;
4. for the subscriber and his or her dependents, the date of the subscriber's death;
5. your group fails to pay us the amount due within 30 days after the day due;
6. upon discovery of fraud or intentional misrepresentation of a material fact by you or your group;
7. at any time your group fails to comply with the contribution or participation rules in the enrollment agreement;
8. when none of your group's members still live, reside or work in Alabama; or,
9. on 30 days advance written notice from your group to us.

In all cases the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other employees in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Will I Lose My Coverage During a Leave of Absence?

If your employer is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your employer to determine whether leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to 30 days during an employer-approved leave of absence, including sick leave. Contact your employer to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your employer for information about your rights to continue coverage under the plan.

COBRA COVERAGE

What Is COBRA; Does It Apply to Me?

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event.

Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer-sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan.

You must contact your plan administrator (normally your employer) to determine whether this plan is covered by COBRA. Blue Cross is not your plan administrator.

COBRA coverage can be particularly important for several reasons. First, it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it. Second, it can prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy pre-existing condition exclusion periods if they obtain health coverage elsewhere). And third, it could allow you to qualify for coverage under the Alabama Health Insurance Program (AHIP). See the discussion below under "What Happens When COBRA Coverage Ends?" for more information about this. You do not have to demonstrate evidence of insurability in order to qualify for COBRA coverage.

You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes. If the employer stops providing health care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your employer to determine if you have further rights under COBRA.

What Are My COBRA Rights if I Am a Covered Employee?

If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your employer continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

If the plan provides health coverage for retired employees, sometimes filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and the bankruptcy results in the loss of coverage of any covered retired employee, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage.

What Are My COBRA Rights if I Am a Covered Spouse?

If you are covered under the plan as a spouse of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes enrolled in Medicare; or
- you become divorced from your spouse.

If your spouse cancels your coverage in anticipation of divorce and a divorce later occurs, your divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your spouse canceled your coverage in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce). See the discussion below under "Do I Have to Give Notice of any Qualifying Events?" and "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about your responsibility to give timely notice of your divorce and the procedures for doing so.

What Are My COBRA Rights if I Am a Dependent Child?

If you are covered under the plan as a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare;
- your parents become divorced; or
- you lose dependent child status under the plan.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical child support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

How Long will COBRA Last if I Am a Covered Spouse or Dependent Child?

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time.

If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last. For example, if a covered employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event that is termination of employment (36 months minus 8 months).

Do I Have to Give Notice of any Qualifying Events?

Yes.

You will be offered COBRA coverage only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. See the discussion below under "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about the notice procedures you must use to give this notice. *If you do not follow these notice procedures or if you do not give the plan administrator notice of your divorce or a child losing dependent status under the plan within the 60-day notice period, you will not be permitted to buy COBRA coverage as a result of divorce or a child losing dependent status.*

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer if the plan provides retiree health coverage, or the employee's becoming enrolled in Medicare the employer must notify the plan administrator of the qualifying event.

Can COBRA Coverage be Extended if I Am Disabled?

Yes. In certain circumstances you can take advantage of a special disability extension.

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the plan administrator, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under "Can COBRA Coverage be Extended if I have a Second Qualifying Event?" for more information about this.

Do I Have to Give Notice of Social Security's Disability Determination?

Yes.

For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event,or (iii) the date of Social Security's determination. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits. See the discussion below under "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about the notice procedures you must use to give this notice. *If you do not follow these notice procedures or if you do not give the plan administrator notice of Social Security's disability determination within the required notice period, you will not be entitled to this disability extension of COBRA coverage.*

Can COBRA Coverage be Extended if I have a Second Qualifying Event?

Yes. In certain circumstances spouses and children can take advantage of a special second qualifying event extension.

For spouses and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to spouses and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare or gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying

event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

Do I Have to Give Notice of Second Qualifying Events?

Yes.

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the discussion below under "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about the notice procedures you must use to give this notice. *If you do not follow these notice procedures or if you do not give the plan administrator notice of the second qualifying event within the required 60-day notice period, you will not be entitled to an extension of COBRA coverage as a result of the second qualifying event.*

What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?

Any notices that you give must be in writing. Oral notice, including notice by telephone, is not acceptable. Your notice must be received by the plan administrator or its designee no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand deliver your notice to the plan administrator at the address listed in the last paragraph entitled "Plan Administrator Contact Information" at the end of this booklet. Your notice must state (i) the name of the plan, (ii) the covered employee's name and address, (iii) the name(s) and address(es) of all qualified beneficiary(ies), (iv) the initial qualifying event and the date of the event, and (v), when applicable, the second qualifying event and the date of the event. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

For your notice of Social Security's disability determination, if you are instructed to send your COBRA premiums to Blue Cross, you must mail or hand deliver your notice to Blue Cross at the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, Alabama 35298-0001 or fax your notice to Blue Cross at 1-205-220-6884 or (toll-free) 1-888-810-6884. If you do not send your COBRA premiums to Blue Cross, you must mail or hand deliver your notice to the plan administrator at the address listed in the last paragraph entitled "Plan Administrator Contact Information" at the end of this booklet. Your notice must state (i) the name of the plan, (ii) the covered employee's name and address, (iii) the name(s) and address(es) of all qualified beneficiary(ies), (iv) the qualifying event and the date of the event, (v) the name of the disabled person, (vi) the date the disabled person became disabled, and (vii) the date of Social Security's determination of disability. Your notice must also include a copy of Social Security's disability determination. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

Can I Add Newly Acquired Dependents to My COBRA Coverage?

Yes, but only under circumstances permitted under the health plan. In addition, except as explained below, any new dependents that you add to your coverage will not have independent COBRA rights. That means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the plan administrator of Social Security's disability determination as explained above. The election should be made on the child's behalf by the child's legal guardian.

I Am Age 65 or Older and about to Retire. Can I Have Medicare and COBRA Coverage at the Same Time?

Yes, but there are a few things that you need to consider.

Most importantly, you should consider whether it is more beneficial to purchase a Medicare supplemental contract instead of COBRA coverage. After you retire, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Medicare. This means that, regardless of whether you have enrolled in Medicare, your COBRA coverage after retirement will not cover most of your hospital and medical expenses. Call the benefits coordinator at the employer for more information about this.

If you think you will need both Medicare and COBRA after your retirement, you should enroll in Medicare *on or before* the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your retirement. If you do not enroll in Medicare *on or before* the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you retire.

Are There Election Rules That Apply to COBRA?

Yes.

After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (i) notifying you that you have the option to buy COBRA, and (ii), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (i) the date you would lose coverage under the plan, or (ii), the date on which the employer notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date sent back to the employer.

Once the employer has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

Can My COBRA Coverage Terminate Early?

Yes.

Your COBRA coverage will terminate early if any of the following events occurs:

- the employer no longer provides group health coverage to any of its employees;
- you do not pay the premium for your continuation coverage on time;
- after electing COBRA coverage, you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you;
- after electing COBRA coverage, you become enrolled in Medicare; or,
- you are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If you are buying COBRA coverage and you become covered under a group health plan that contains a pre-existing condition limitation or exclusion that *does* apply to you (for example, you do not have enough creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you), you should discuss the situation with the sponsor of the new plan (usually the new employer) to determine whether it makes sense nonetheless for you to enroll in the new plan while continuing to pay for COBRA coverage at the same time. Since some plans limit the circumstances under which employees and their families may enroll, it is best to consult with the new employer concerning the interaction of COBRA and the new employer's group health coverage.

Can COBRA Benefits Change?

Yes, as and when benefits under the group health plan change.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the employer changes the group coverage, coverage will also change for you.

When Must COBRA Premiums be Paid?

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30 days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

What Happens When COBRA Coverage Ends?

If you exhaust your COBRA coverage you may buy a conversion health contract from Blue Cross. Please contact Blue Cross to determine whether a conversion contract is available. Conversion contracts have more limited coverage than COBRA coverage.

You may also qualify for coverage under state law. In Alabama, you can continue coverage through the Alabama Health Insurance Plan (AHIP). You can reach AHIP by calling the State Employees' Insurance Board in Montgomery, Alabama. In other states, you should call the state insurance department. If you elect to buy a conversion contract instead of enrolling in AHIP, you will not be able to enroll at a later date in AHIP.

By contrast, if COBRA coverage ends because you stop paying for it, then you will not have any further coverage under the group health plan and you will not be eligible to buy conversion coverage (if available) and you may not qualify for continued coverage under any applicable state law program. For example, in Alabama, you would not qualify for continued coverage under AHIP.

If you have any further questions about COBRA or **if you change marital status, or you or your spouse or child changes address, please contact your plan administrator.** Additional information about COBRA can also be found at the web site of the Employee Benefits Security Administration of the United States Department of Labor.

CERTIFICATES OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) creates a concept known as "creditable coverage." Your coverage under this plan is considered creditable coverage. If you have sufficient creditable coverage under this plan and you do not incur a break in coverage (63 continuous days of no creditable coverage), you may be able to reduce or eliminate the application of a pre-existing illness exclusion in another health plan. See the section of this summary dealing with pre-existing condition periods for an explanation of how this works.

At any time up to 24 months after the date on which your coverage ceases under the plan, you may request a copy of a certificate of creditable coverage. In order to request this certificate, you or someone on your behalf must call or write Customer Service.

BENEFIT CONDITIONS

To qualify as plan benefits, medical services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective;

2. Services or supplies for any pre-existing condition must be furnished after the 12-month (365 days) or 18-month (546 days) pre-existing condition exclusion period;

3. We must determine before, during or after services and supplies are furnished that they are medically necessary;

4. PPO benefits must be furnished while you are covered by this plan and the provider must be a PPO Provider when the services or supplies are furnished to you;

5. Separate and apart from the requirement in paragraph 4. above, services and supplies must be furnished by a provider (whether a Preferred Provider or not) who is recognized by us as an approved provider for the type of service or supply being furnished. For example, we reserve the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call Customer Service if you have any question whether your provider is recognized by us as an approved provider for the services or supplies you plan on receiving;

6. Services and supplies must be furnished when the plan and your coverage both are in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

HEALTH BENEFITS

All benefits are subject to all deductibles, conditions, limitations and exclusions of the plan.

BEFORE YOUR HOSPITAL ADMISSION--CAUTION: One of several requirements for hospital benefits is that we certify the medical necessity of your hospital stay in advance, except for emergencies and when you are admitted to a Concurrent Utilization Review Hospital by a Preferred Medical Doctor. Emergency admissions require notice to us within 48 hours and must also be certified by us as both medically necessary and as an emergency admission. You may appeal these decisions. **Failure to obtain our certificate of medical necessity will result in no**

benefits being paid for your hospital stay or the admitting physician. Just because we certify a hospital admission as medically necessary does NOT mean we have decided to pay benefits for it. For example, the admission may be for a pre-existing condition or any other excluded condition.

Inpatient Hospital Benefits in a PPO or Participating Hospital (in Alabama) or a PPO Hospital (Outside of Alabama)

1. Bed and board and general nursing care in a semiprivate room; **or**
2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them; **and**
3. Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
4. Administration of anesthetics by hospital employees and all necessary equipment and supplies;
5. Casts and splints, surgical dressings, treatment and dressing trays;
6. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and x-rays;
7. Physical therapy, hydrotherapy, radiation therapy and chemotherapy;
8. Oxygen and equipment to administer it;
9. All drugs and medicines used by you and administered in the hospital;
10. Regular nursery care and diaper service for a newborn baby while its mother has coverage;
11. Blood transfusions administered by a hospital employee.

Inpatient Hospital Benefits for Maternity

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity.

PPO (Preferred Provider Organization) Outpatient Facility Benefits

1. Emergency treatment of an accidental injury;
2. Chemotherapy and radiation therapy;
3. IV therapy;
4. Hemodialysis;
5. X-rays, lab and pathology services;
6. Medical emergency (subject to copay);

7. Surgery (subject to copay).

Preferred Home Health and Hospice Care

Benefits provided for home health care services include skilled nursing visits ordered by a physician, rendered in a patient's home by a Registered Nurse (R.N) or Licensed Practical Nurse (L.P.N.), and billed by a home health agency. Other services included under the Home Health benefit are home infusion therapy and related medications, when these services are rendered in the patient's home by a home health care provider, and billed by a home health care agency. Any precertification requirements and/or any specified benefit maximums noted in the Summary of Health Benefits are applicable to skilled nursing visits only.

Services such as speech therapy, occupational therapy and physical therapy may be billed by a home health care agency; however, these services are not part of the home health benefit but may be considered under another portion of the contract.

Benefits provided for hospice service includes supplies or drugs included in the daily fee for hospice care rendered by a hospice provider to a terminally ill member when a physician certifies the member's life expectancy to be less than six months.

Physician Benefits

1. Surgery, which includes preoperative and postoperative care, reduction of fractures and endoscopic procedures;
2. Anesthesia for a covered service;
3. Second surgical opinion services;
4. Obstetrical care for childbirth, pregnancy, and the usual care before and after those services;
5. Inpatient visits while you're a hospital patient for other than surgery, obstetrical care, or radiation therapy except for an unrelated condition;
6. Consultation for a medical, surgical or maternity condition but only one for each hospital stay;
7. Diagnostic lab, x-ray and pathology services in a physician's office when related to covered services but not allergy testing;
8. Radiation therapy and chemotherapy;
9. Care in the emergency room of a hospital for other than surgery or maternity (subject to copay);
10. Exam, diagnosis, and treatment for an illness or injury.

Note: Please see Other Covered Services for allergy testing and treatment.

PPO Preventive Services

1. Routine immunizations (see **www.bcbsal.com/immunizations** for a listing a specific immunizations);
2. Inpatient visits by a PPO for routine newborn care;
3. One routine pap smear a year for females;
4. One baseline mammogram for females ages 35-39; one mammogram a year for ages 40 and over. See Mastectomy and Mammograms (later in this booklet) for additional informational;

5. One prostate specific antigen test each year for males ages 40 and over;

6. One PPO office visit a year when combined with a routine pap smear, mammogram or prostate screening (subject to copay);

7. Nine office visits for the first two years of a baby's life; annual exams for ages two through six (subject to copay).

Prescription Drug Benefits

1. Prescription drug benefits are only available for prescriptions purchased from Participating Pharmacies, which are available in all states. Prescriptions purchased from Non-Participating Pharmacies in any state are not covered. Participating Pharmacies bill us and we pay them. You pay only the copay or the amount of the drug if it is less than the copay. You can determine whether a pharmacy is a Participating Pharmacy by going to our website at www.bcbsal.org.

2. To be eligible for benefits, drugs must be legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal Law prohibits dispensing without a prescription." Compound drugs are covered if at least one of the drugs in the compound is a legend drug. In some cases, drugs may also require prior authorization. Your Participating Pharmacist will advise if this is a requirement.

3. Drugs can be dispensed in a maximum of a 34-day supply for each drug or refill. Refills are allowed only after 60% of the previous prescription has been used, e.g., 18 days into a 30-day supply.

4. Maintenance drugs (including certain diabetic supplies) can be dispensed in the greater of a 60-day supply or 100 unit doses. Participating Pharmacies should have a list of maintenance drugs.

5. Insulin, needles and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Blood glucose strips and lancets purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Glucose monitors always have a separate copay. The copay that applies depends on whether the monitor or supplies are generic, Preferred Brand, or Non-Preferred Brand, as set out in the Prescription Drugs section in the Summary of Health Benefits. These are the only diabetic supplies available through the Prescription Drug program.

Other Covered Services

1. Semiprivate room and board, general nursing care, and all necessary hospital services and supplies when your inpatient hospital benefits are all used.

2. Outpatient hospital services.

3. Anesthesia for surgery or obstetrical care when given by other than the surgeon, obstetrician or hospital employee.

4. Physical therapy and hydrotherapy given by a licensed physical therapist.

5. Allergy testing and treatment.

6. Artificial arms and other prosthetics; leg braces and other orthopedic devices.

7. Medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints.

8. Treatment of natural teeth injured by a force outside your mouth or body, if service is received within 90 days of the injury.

9. Professional ambulance service to the closest hospital that could treat the condition.

10. The less expensive for rental or purchase of durable medical equipment such as wheelchairs and hospital beds.

11. Hemodialysis services of a Participating Renal Dialysis Facility.

12. Treatment of mental and nervous disorders including alcoholism and drug addiction.

13. Chiropractic services. Participating Chiropractors may be required to precertify services during the course of your treatment. If so, the Participating Chiropractor will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

14. Phase I therapy and exams for TMJ disorders according to the guides of the American Academy of Craniomandibular Disorders.

15. Occupational therapy performed by a licensed occupational therapist.

16. Chiropractic Services.

Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term, and chronic illness or injury. If you have a catastrophic, long-term or chronic illness or injury, a Blue Cross Registered Nurse may assist you in accessing the most appropriate health care for your condition. The nurse case manager will work with you, your physician, and other health care professionals to design a treatment plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to you and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through Individual Case Management are subject to your benefit contract maximums. If you think that you may benefit from Individual Case Management, please call the Health Management division at (205)733-7067 or 1-800-821-7231.

If you suffer from certain long-term, chronic, diseases or conditions you may qualify to participate in the Care Management Program. Care Management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the Care Management Program determines from your claims data that you are a good candidate for Care Management, the manager will contact you and ask if you would like to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call Customer Service at the number on the back cover.

Organ, Tissue and Bone Marrow/Cell Transplants

The organs and tissue for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas; (5) kidney; (6) heart-valve; (7) skin; (8) cornea; and (9) small bowel. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. The transplant must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Donor organ costs are limited to search, removal, storage and the transporting the organ and removal team.

There are no transplant benefits for: (1) any artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) recipient or donor room, food, or transportation costs we did not approve in writing; (7) a condition or disease for which a transplant is considered investigational; (8) transplants performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Mastectomy and Mammograms

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Benefits for Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.
- If you are at high risk of developing breast cancer or you have a family history of breast cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.
- In all other cases the claim will be subject to the routine mammogram benefit provisions and limits described elsewhere in this booklet.

Colorectal Cancer Screenings

Benefits for colorectal cancer screenings vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.
- If you have family history of colon cancer – within the meaning of our medical guidelines – and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.
- In all other cases the claim will be subject to the routine colorectal cancer screening benefit provisions with the age and frequency limitations described elsewhere in this booklet.

COORDINATION OF BENEFITS (COB)

COB is a provision designed to help manage the cost of health care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's health care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan.

Which plan is primary is decided by the first rule below that applies (note, however, that if the other plan is Medicare the order of benefit determination is determined by the applicable Medicare secondary payer laws):

1. If the other plan has no COB provision, it is primary.

2. Employee/Dependent: The plan covering a patient as an employee, member, or subscriber (that is other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

3. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If the other plan does not use this "birthday rule" the other plan's rule will be used.

4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:

    a. first, the plan of the parent with custody;

    b. second, the plan of the spouse of the parent with custody;

    c. third, the plan of the parent without custody; and

    d. last, the plan of the spouse of the parent without custody.

    If the divorced or separated parents have joint legal custody, benefits are determined as if the parents are not separated or divorced (see paragraph 3 above).

    If there is a court order that specifically states that one parent must provide for the child's health expenses or provide health insurance coverage for the child, benefits are determined in this order:

    a. first, the plan of the court-ordered parent;

    b. second, the plan of the spouse of the court-ordered parent;

    c. third, the plan of the non-court-ordered parent; and,

    d. last, the plan of the spouse of the non-court-ordered parent.

5. Active/Inactive Employee: When a patient is covered under one plan as an active employee and under another plan as a retired or inactive employee (e.g., a former employee receiving COBRA benefits), the plan which covers the patient as an active employee is primary over a plan which covers the patient as a laid-off or retired employee. This applies to the employee's dependents as well unless the dependents have other coverage due to their own current or former employment status.

6. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

SUBROGATION

Right of Subrogation

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we've paid plan benefits. This means that you promise to repay us from any money you recover the amount we've paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you aren't made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

CLAIMS AND APPEALS

The following explains the rules under your group health plan for filing claims and appeals.

Remember that you may always call our Customer Service Department for help if you have a question or problem that you would like us to handle without an appeal. The phone number to reach our Customer Service Department is on the back of this booklet.

In General

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how we process these different types of claims and how you can appeal a partial or complete denial of a claim.

The claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Even if your plan is not covered by ERISA, we will process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of your booklet.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling our Customer Service Department. You can also go to our Internet web site at http://www.bcbsal.com/ and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

Post-Service Claims

What Constitutes a Claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. The most common example of this is medical records that we may need in order to determine whether services or supplies were medically necessary. If we need this sort of additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

Who Gets Paid: Some of the contracts we have with providers of services, such as hospitals, require us to pay benefits directly to the providers. With other claims we may choose whether to pay you or the provider. If you or the provider owes us money we may deduct the amount owed from the benefit paid. When we pay or deduct the amount owed from you or the provider, this completes our obligation to you under the plan. We need not honor an assignment of your claim to anyone. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain precertification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If we grant a pre-service claim, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines. For example, we might precertify your inpatient hospital admission but later deny your claim because the admission related to a pre-existing condition or was for a service or supply that is excluded under the plan.

In order to file a pre-service claim you or your provider must call our Health Management Department at 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from a

Participating Chiropractor, Preferred Physical Therapist, or Preferred Occupational Therapist, your provider is responsible for initiating the precertification process for you. For home health care and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (i) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (ii), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims: We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing within three days. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing the information to us.

Non-Urgent Pre-Service Claims: If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

Courtesy Pre-Determinations: For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call our Customer Service Department.

Concurrent Care Determinations

Determinations by us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Member Satisfaction

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write our Customer Service Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Your satisfaction is important to us. We will do our utmost to maintain it.

Appeals

In General: The rules in this section of the booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- our denial of a pre-service claim; or,
- an adverse concurrent care determination (for example, we deny your request to extend previously approved care).

In all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to our Internet web site at http://www.bcbsal.com/. Once there, you may ask us to send a copy of the form to you.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- the patient's name;
- the patient's contract number;
- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P. O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

  Blue Cross Blue Shield of Alabama
  Attention: Health Management – Appeals
  P. O. Box 2504
  Birmingham, Alabama 35201-2504

  and

- For Preferred Physical Therapy, Occupational Therapy, or care from a Participating Chiropractor (when covered by your plan):

  Blue Cross Blue Shield of Alabama
  Attention: Health Management – Appeals
  P. O. Box 362025
  Birmingham, Alabama 35236

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

Conduct Of The Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a health care professional who has appropriate expertise. If we consulted a health care professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

We will consider your appeal fully and fairly.

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a post-service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), we will make a decision on your appeal as soon as possible, but in any event before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- you may ask our Customer Service Department for further help;
- you may file a voluntary appeal (discussed below); or,
- you may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The employer has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of administrative services under the plan. Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan and thereafter to judicial review to determine whether our determination was arbitrary or capricious.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so. Mail notices to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858, with your full name and contract number. We get notice when it arrives at this address.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will show in your Claim Report.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we cannot be responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you make any material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage. If your group materially misrepresents its application it will be as though the plan never took effect, and we need not even refund any payment for any member.

PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

The confidentiality of your personal health information is important to us. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section of the booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting your employer's human resources office.

Disclosures of Protected Health Information to the Plan Sponsor: In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your employer). Here are the circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.

- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.

- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Here are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.

- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.

- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of the booklet.

- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.

- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.

- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or health care operations.

- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.

- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

Corporate Human Resources Manager

Benefit Administration Supervisor

Vice President, Human Resources

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions - which may include termination of employment. If the plan sponsor becomes aware of any violation like this, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

Security of Your Personal Health Information: Here are the restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information on and after April 21, 2005 (or, on and after April 21, 2006 if this plan is a small health plan):

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.

- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

- The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information: As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama) have an agreement with the plan that allows us to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

Multiple Coverage

If you are covered both by this contract and by a non-group contract we issue, you will be entitled to benefits only under the one that provides the most coverage for you.

Applicable Law

The federal ERISA law governs this plan. If any state law applies, the law of Alabama governs.

Plan Terminations

1. The plan may be terminated at any time by either the group or Blue Cross by giving 30 days notice in writing to the other.

2. The plan may be terminated by Blue Cross immediately by notice in writing to the group when the group has other group health coverage.

3. If the group fails to pay the amount due within 30 days after it becomes due, the plan will terminate automatically and without notice to you or the group as of the date due for the payment.

Plan Changes

1. By giving 30 days notice in writing to the group, we may change the amount of the payment for coverage or change, add, or remove any other provisions in the plan or in your coverage without sending individual notices to you only. The group solely is responsible for notifying you of the change. The change will be effective whether or not the group notified you of the change, and we are not responsible for any failure to do so.

   The notice of change will state the effective date of the change. The change will apply to all benefits for services you receive on or after the stated effective date. If the group submits payment for coverage to us after a notice of changes, it will be considered acceptance by you and the group of the new payment amount or other plan changes.

2. By written agreement between the group and Blue Cross, signed by Blue Cross's officer, the plan and any of its provisions and coverage may be changed, removed, or added without sending individual notices to you.

3. The plan can be changed only through changes made in writing and signed by Blue Cross's officer in the manner stated above. None of Blue Cross's representatives, officers, employees, or agents can make any contract changes orally, as by telephone, or in any other way except in writing as described above.

Out-of-Area Co-Pay and Co-Insurance

When you obtain health care services through the BlueCard Program outside of the Alabama service area, the amount you pay for covered services is calculated on the **lower** of:

1. The billed charges for your covered services, or

2. The negotiated price that the on-site Blue Cross and/or Blue Shield plan ("Host Plan") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in paragraph one of

this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

HEALTH BENEFIT EXCLUSIONS

We **will not** provide benefits for the following:

1. Services or expenses we determine are not medically necessary.

2. Services, care, or treatment you receive during any period of time that we have not been paid for your coverage and that nonpayment results in plan termination.

3. Services, care, or treatment you receive after the date your coverage ends. This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.

4. Services or expenses for cosmetic surgery. "Cosmetic surgery" is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See the section, Women's Health and Cancer Rights Act, for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

   a. Please contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual fields measures and photographs before and after surgery.

   b. Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and many sinus infections. To correct this they have a septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance but reconstructive if done because your eyelids kept you from seeing very well.

5. Services or expenses to care for, treat, fill, extract, remove or replace teeth or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. Braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw. With the exception of braces, which are never covered under the medical plan, this exclusion

does not apply to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Supplemental Accident and Other Covered Services.

6. Dental implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses, even if medically or dentally necessary, are not covered under the medical plan even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. Services or expenses in cases covered in whole or in part by workers' compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for hospital or medical services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

7. Services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provides or pays for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

8. Services or supplies to the extent that a member is, or would be, entitled to reimbursement under Medicare, regardless of whether the member properly and timely applied for, or submitted claims to, Medicare, except as otherwise required by federal law.

9. Routine well child care and routine immunizations except as provided in PPO benefits.

10. Routine physical examinations except as provided in PPO benefits.

11. Services or expenses for custodial care. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

12. Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including services that are part of a clinical trial.

13. Services or expenses for routine foot care such as removal of corns or calluses or the trimming of nails (except mycotic nails).

14. Hospital admissions in whole or in part when the patient primarily receives services to rehabilitate such as physical therapy, speech therapy, or occupational therapy.

15. Services and expenses provided to a hospital patient which could have been provided on an outpatient basis, given the patient's condition and the services provided. Benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospital stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy and hydrotherapy.

16. Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease or which are related to surgical sex transformations.

17. Services for or related to pregnancy, including the six-week period after delivery, of any dependent other than the employee's wife.

18. Services or expenses for an accident or illness resulting from war, or any act of war, declared or undeclared, or from riot or civil commotion.

19. Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution.

20. Services or expenses for which a claim is not properly submitted to Blue Cross.

21. Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of the Claims Administrator. Benefits will only be provided for one surgical procedure for obesity (morbid) in a lifetime. Benefits will not be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure.

22. Services or expenses which you are not legally obligated to pay, or for which no charge would be made if you had no health coverage.

23. Services or expenses for or related to organ, tissue or cell transplantations except specifically as allowed by this plan.

24. Dental treatment for or related to temporomandibular joint (TMJ) disorders. This includes Phase II, according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth or a combination of these treatments.

25. Services or expenses for or related to Assisted Reproductive Technology (ART). ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

26. Eyeglasses or contact lenses or related examination or fittings. One pair of eyeglasses, contact lenses or one pair of each will be covered under Other Covered Services if they replace the lens of the eye after eye surgery or injury or defect.

27. Services or expenses for eye exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

28. Services or expenses for personal hygiene, comfort or convenience items such as air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

29. Services or expenses for speech, recreational, educational, or occupational (except as stated covered previously) therapy.

30. Services or expenses for acupuncture, biofeedback and other forms of self-care or self-help training.

31. Hearing aids or examinations or fittings for them.

32. Services or expenses of a hospital stay, except one for an emergency, unless we certify it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

33. Services or expenses of private duty nurses.

34. Services provided by Psychiatric Specialty Hospitals which do not participate with nor are considered members of any Blue Cross and/or Blue Shield Plan.

35. Services, care, treatment, or supplies furnished by a provider that is not recognized by us as an approved provider for the services rendered as explained more fully in paragraph 5. under the section of this summary called "Benefit Conditions."

36. Services or expenses any provider rendered to a member who is related to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physical therapist.

37. Services provided by Substance Abuse Facilities including Substance Abuse Residential Facilities.

38. Services and expenses rendered by a Non-Preferred Home Health Care or Non-Preferred Hospice provider in Alabama.

39. Services or expenses of any kind for nicotine addiction such as smoking cessation treatment. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from a Participating Pharmacy.

40. Drugs or medicines dispensed from a pharmacy which is not a Participating Pharmacy.

41. Travel, even if prescribed by your physician.

42. Inpatient care or treatment for mental and nervous disorders or disease (including alcoholism and drug addiction) is excluded once the basic hospital days are exhausted.

43. Services or expenses of any kind provided by a Non-Participating Hospital located in Alabama for any benefits under this plan, except for inpatient and outpatient hospital benefits in case of accidental injury and for outpatient hospital service benefits in case of accidental injury, as more fully described under "Inpatient Hospital Benefits" and "Outpatient Hospital Benefits."

44. Services or expenses for a claim we have not received within 24 months after services were rendered or expenses incurred.

45. Services or expenses for physical therapy which does not require a licensed physical therapist, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency or duration.

46. Services or expenses in any federal hospital or facility except as provided by federal law.

47. Services or expenses for sanitarium care, convalescent care, or rest care.

48. Anesthesia services or supplies, or both, by local infiltration.

49. Services provided through teleconsultation.

50. Services provided by a Non-Participating Renal Dialysis Facility in Alabama.

DEFINITIONS

Accidental Injury: A traumatic injury to you caused solely by an accident.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

1) **Preferred Providers:** Blue Cross and Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the preferred provider normally accepts this rate (subject to any applicable copays, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services or care. The negotiated price applies only to services that are covered under the Plan and also covered under the contract that has been signed with the preferred provider. Please be aware that not all participating or contracting providers are preferred providers. Each local Blue Cross and/or Blue Shield plan determines which of its participating or contracting providers will be considered preferred providers.

2) **Non-Preferred Providers:** The Allowed Amount for care for non-preferred providers or for services or supplies not included in a preferred provider's contract is normally determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to preferred providers, or may be based on the average or anticipated charge or discount for care in the area or state, or for care from that particular type of provider. When the local Blue Cross and/or Blue Shield plan does not provide us with appropriate pricing data or when we are determining the Allowed Amount for services or supplies by a non-preferred provider (or for services and supplies not included in the contract with the provider), Blue Cross and Blue Shield of Alabama determines the Allowed Amount using historical data and information from various sources such as, but not limited to:

   - The charge for the same or a similar service;
   - The relative complexity of the service;
   - The preferred provider allowance for the same or a similar service;
   - The average expected or estimated provider discount for the type of provider in the service area, as reported by the Blue Cross and Blue Shield Association from time to time;
   - Applicable state health care factors;
   - The rate of inflation using a recognized measure; and,
   - Other reasonable limits, as required with respect to outpatient prescription drug costs.

   Non-preferred providers include providers that have not signed a contract with the Blue Cross and/or Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue

Cross and/or Blue Shield plan as preferred providers.

In this situation the provider may bill the member for charges in excess of the Allowed Amount. The Allowed Amount will not exceed the amount of the provider's charge.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care," "Individual Case Management," and "Care Management."

Application: The subscriber's original application form and any written supplemental application we accept.

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

Blue Cross: Blue Cross and Blue Shield of Alabama.

BlueCard Program: An arrangement among Blue Cross Plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

Certification of Medical Necessity: The written results of our review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not mean that your group has paid us all monies due for you. Certification of medical necessity does not consider whether your admission is excluded by this plan.

Chiropractic Fee Schedule: The schedule of chiropractic procedures and corresponding fee amounts for Participating Chiropractic Benefits.

Concurrent Utilization Review Program (CURP): A program designed to promote the most efficient and effective use of health care resources while utilizing cost-effective methods to administer benefits.

Contract: The Group Health Benefits contract between your Employer and Blue Cross and Blue Shield of Alabama. The contract is made up of (1) your employer's Group Application for the contract; (2) this Summary Plan Description; and (3) any written change to this Summary Plan Description. Your contract number is listed on your ID card.

Contract Effective Date: The date the Group Health Benefits contract becomes effective; the same date we accept the Group Application.

Cosmetic Surgery: Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma or birth defect. For important information on cosmetic surgery, see the "Exclusions" section.

Custodial Care: Care primarily to provide room and board for a person who is mentally or physically disabled.

Dependent: See the explanation in the "Eligibility and Enrollment" section.

Durable Medical Equipment: Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

Effective Date: The date on which the coverage of each individual subscriber and dependent begins as listed in Blue Cross's records.

Eligible Person: Any employee or member of the group or other person who meets the eligibility standards of their plan and is designated as eligible to us by the group.

Family Coverage: Coverage for a subscriber and one or more dependents.

Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Group: The employer, association, or other entity which contracts with Blue Cross and through which you have coverage.

Group Application: The document in which the employer applies to us for a group benefits plan.

Home Health Care Agency: A Preferred or a Non-Preferred Home Health Care Agency.

Hospice: A Preferred or a Non-Preferred Hospice.

Hospital: A Participating or a Non-Participating Hospital as defined in this plan.

Individual Case Management: Benefits which are an alternative to more expensive covered benefits. They provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care" and "Care Management."

Inpatient: A registered bed patient in a hospital.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,

- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by attending physician and other medical providers.

Medical Emergency: A medical condition that occurs suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

Medically Necessary or Medical Necessity: We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical criteria) that we use to determine medical necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, we will not pay for it. If a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- provided for the diagnosis or direct care and treatment of your medical condition;
- in accordance with standards of good medical practice accepted by the organized medical community;
- not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- not "investigational;" and,
- performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Member: A subscriber or eligible dependent who has coverage under the contract. The term member also refers to a former dependent or subscriber who was not terminated for gross misconduct, who is eligible for and covered under COBRA.

Mental and Nervous Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental and nervous disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental and nervous disorders however they are caused,

based or brought on. Mental and nervous disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Non-Participating Chiropractor: A Doctor of Chiropractic (D.C.) who is not a Participating Chiropractor.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "special" hospitals. Examples of these "special" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Participating Pharmacy: Any pharmacy which is not a Participating Pharmacy.

Non-PPO Provider: Any provider which is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

Non-Preferred Brand: Any brand name drug that is not a Preferred Brand.

Non-Preferred Home Health Care Agency: Any home health care agency which is not a Preferred Home Health Care Agency.

Non-Preferred Hospice: Any hospice which is not a Preferred Hospice.

PPO: Preferred Provider Organization.

PPO Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

PPO Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

PPO Hospital, PPO Physician, PPO Provider, or Preferred Provider: Any hospital, physician, or provider with which any Blue Cross and/or Blue Shield Plan has a PPO contract for the furnishing of health care services.

Participating Ambulatory Surgical Facility: Any facility with which Blue Cross and Blue Shield of Alabama has a Participating Ambulatory Surgical Facility contract for furnishing health care services.

Participating Chiropractor: A Doctor of Chiropractic (D.C.) who has an agreement with Blue Cross.

Participating Hospital: Any hospital with which Blue Cross and/or Blue Shield Plan has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which Blue Cross or its subsidiary, Preferred Care Services, Inc., has a contract for dispensing prescription drugs.

Participating Renal Dialysis Facility: Any freestanding hemodialysis facility with which Blue Cross and Blue Shield of Alabama has a contract for furnishing health care services.

Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), and Psychologist (Ph.D. or Psy.D.), as defined in Section 27-1-18 of the Alabama Code.

Plan: This Summary Plan Description (SPD) describing the benefits of your Employee's Health Benefits Plan.

Preadmission Certification and Postadmission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or within 48 hours or the next business day after the admission in the case of an emergency admission, based upon medically recognized criteria.

Preferred Brand: Brand name drugs that combine effectiveness and cost efficiency, as determined by an expert group of physicians and pharmacists serving on the Blue Cross and Blue Shield of Alabama Pharmacy and Therapeutics Committee.

Preferred Care: A program whereby providers have agreements with Blue Cross to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, certain services and supplies to members entitled to benefits under the Preferred Care Program.

Preferred Home Health Care Agency: Any home health care agency inside or outside of Alabama with which Blue Cross has a contract.

Preferred Home Health Care Fee Schedule: The schedule of procedures and the fee amounts listed in the Preferred Home Health Care Fee Schedule or the amount of the Preferred provider's actual charge, whichever is less for Preferred Home Health Care Benefits.

Preferred Hospice: Any hospice inside or outside of Alabama with which Blue Cross has a contract.

Preferred Medical Doctor or Preferred Physician: A physician who has an agreement with Blue Cross to provide surgical and medical services to members entitled to benefits under the PPO Program or another Preferred Care Program through a contract with Blue Cross.

Preferred Provider Organization (PPO): Hospitals, physicians, or other providers who have agreements with any Blue Cross and Blue Shield Plan to provide surgical and medical services to members entitled to plan benefits under the PPO Program.

Preferred Radiology Provider or PRP: Any provider with which Blue Cross and Blue Shield of Alabama has a contract for the furnishing of diagnostic radiology procedures such as computerized axial tomography (CAT scan) and magnetic resonance imaging (MRI scan).

Pregnancy: The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body-usually, but not always, in the uterus-and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Private Duty Nursing: Nursing care provided in the patient's home by a licensed professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who does not reside in the patient's home and is not related to the patient by blood or marriage.

Radiology Schedule: The schedule of radiological procedures which is on file and available for examination at the Birmingham offices of Blue Cross.

Subscriber: The employee whose application for coverage under the contract is made and accepted by Blue Cross.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider.

We, Us, Our: Blue Cross and Blue Shield of Alabama.

You, Your: The subscriber or member as shown by context.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan.

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Administrative Information

The following information is provided to complete the requirements for making this a Summary Plan Description as outlined in the Employee Retirement Income Security Act.

1. The Plan's official name is: Equity Group – Eufaula Division LLC Group Health Care Plan

2. The Plan Sponsor and Plan Administrator is:

   Equity Group – Eufaula Division LLC
   300 Barr Harbor Drive, Suite 600
   West Conshohocken, Pennsylvania 19428

   Equity Group – Eufaula Division LLC is responsible for discharging all obligations that ERISA and its regulations impose upon Plan Sponsors and Plan Administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law. To the extent not delegated to Blue Cross, Equity Group – Eufaula Division LLC, as plan sponsor, has the discretionary authority to interpret and construe the terms of the plan.

3. The Plan Number assigned by the Plan Sponsor is: 501

4. The IRS Employer Identification Number (EIN) of the Sponsor is: 23-3073393

5. The Plan provides hospital and medical benefits as administered under a contract by Blue Cross and Blue Shield of Alabama under group number 11823/008. Blue Cross has complete discretion to interpret and administer the provisions of the Plan. Its administrative functions include paying claims, determining medical necessity, etc. The address of Blue Cross and Blue Shield of Alabama is 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. The plan benefits are underwritten.

6. The Agent for legal process is:

   Equity Group – Eufaula Division LLC
   300 Barr Harbor Drive, Suite 600
   West Conshohocken, Pennsylvania 19428

7. The records of the health plan are kept on the basis of a plan year which begins on January 1st and ends on the following December 31st.

8. Equity Group – Eufaula Division LLC currently intends to continue the Group Health Care Plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents.

9. This is an Employer-Employee Shared Cost Plan. The sources of the contributions to this Plan are currently the employer and the employee in relative amounts as determined by the employer from time to time. While the employer may change its level of contribution at any time, the employer must always contribute at least a portion of the employee's premiums. Any information concerning what is to be paid by the employee in the future will be furnished by the employer in writing and will constitute a part of this Plan. Your contribution is determined by the employer based on the plan's experience and other factors.

10. Plan Administrator Contact Information:

    Please mail or hand deliver all COBRA notices to your Plan Administrator at the following address:

    Attention: Employee Benefits (COBRA)
    Equity Group – Eufaula Division LLC
    300 Barr Harbor Drive, Suite 600
    West Conshohocken, Pennsylvania 19428

BlueCross BlueShield
of Alabama

450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

Customer Service:

988-2200 (in Birmingham)
or 1 800 292-8868 toll-free

Preadmission Certification:

988-2245 (in Birmingham)
or 1 800 248-2342 toll-free

web site:

www.bcbsal.com

11823/008
Health Plan

08/07

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

ROGER JORDAN,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	2:08-cv-00152-MEF-TFM
EQUITY GROUP EUFAULA DIVISION, LLC, JENNIFER BAKER and RANDY CLINE	)	
	)	
Defendants.	)	

MOTION TO DISMISS
AND TO STRIKE DEMAND FOR JURY TRIAL

Defendants, pursuant to Fed. R. Civ. P. 12(b)(6), 12(f) and 39(a)(2), hereby move the Court to dismiss all of Plaintiff's claims as such claims and demands are preempted by Section 301(a) of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185(a) and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* In addition, Defendants move to strike Plaintiff's demand for a jury trial under ERISA.

In support of this motion, Defendants state the following:

A. Introduction

Plaintiff, Roger Jordan ("Jordan"), was employed by Defendant Equity Group Eufaula Division, LLC ("Equity") as a live hanger in its poultry processing facility in Barbour County, Alabama. [See Complaint, ¶ 5.] Jordan was a member of a union collective bargaining unit and a participant in a group health insurance plan provided by Equity as an employee benefit. The health insurance plan is an employee welfare benefit plan as defined by ERISA. 29 U.S.C. § 1002(a). Jordan's employment with Equity was terminated on or about November 21, 2007. [Complaint, ¶ 5].

On or about January 31, 2008, Plaintiff filed his Complaint in the Circuit Court of Barbour County, Alabama. He alleges his termination of employment and health insurance benefits occurred after Equity learned that he suffered a catastrophic injury while jumping on a trampoline, and his complaint purports to state claims for fraud, outrage, and wrongful termination. Defendants timely removed this case to the United States District Court for the Middle District of Alabama on the basis of federal question jurisdiction, as his purported state law claims are completely preempted by federal labor laws. For similar reasons, this action should now be dismissed.

B. Jordan's Claims Are Governed by a Collective Bargaining Agreement, and Are Thus Preempted By Federal Labor Law And Otherwise Barred

As Jordan well knows, at all times during his employment with Equity, he and all other production workers at the plant were represented by the Retail, Wholesale and Department Store Union ("Union"), for purposes of bargaining with respect to all terms and conditions of employment. Accordingly, the terms of Jordan's employment, including the termination of his employment and his entitlement to health care insurance and other benefits, are subject to and governed by a collective bargaining agreement ("CBA") between Equity and the Union.[1]

[1]Copies of the Collective Bargaining Agreement dated March 1, 2004 and the summary plan description for Equity employee health insurance plan, which were in effect at all relevant times, are attached to this Motion to Dismiss as Exhibits "1" and "2", and may be considered by the Court given the nature of Jordan's claims and, more important, his express reference to Equity's employee handbook and his health insurance benefits as a purported bases for his claims. [Complaint, Count II, ¶ 3.] See Lockwood v. Beasley, 2006 U.S.App.LEXIS 31618, *7-9 (11th Cir. Dec. 20 2006); Orange Beach Dev. Group, L.P. v. Powers, 2007 U.S.Dist.LEXIS 47757, *7 (S.D.Ala. 2007)(court considered bylaws, articles of incorporation and various agreements not referenced in the complaint in context of motion to dismiss; "where the documents referred to in the motion are central to the plaintiff's claim, then the Court may consider the documents part of the pleadings for purposes of Rule 12(b)(6)dismissal"); Bozeman v. Lucent Technologies, Inc., 378 F.Supp.2d 1348, 1350, n.1 (M.D.Ala. 2005)("the court finds that because the relevant documents are indisputable, and their subject matter is otherwise directly referenced in the Complaint, the opt out forms can properly be attached to a motion to dismiss without converting it into a summary judgment motion").

The CBA precludes Jordan's claims as a matter of law for several reasons.

1. Jordan's State Law Claims Are Preempted By Federal Labor Law.

In Teamsters, Chauffeurs, Warehousemen & Helpers v. Lucas Flour Co., 369 U.S. 95, 82 S.Ct. 571 (1962), the Supreme Court held that Section 301(a) of the Labor Management LMRA, 29 U.S.C. § 185(a), preempts any state law claims for breach of a collective bargaining agreement:

> The possibility that individual contract terms might have different meanings under state and federal law would inevitably exert a disruptive influence upon both the negotiation and administration of collective agreements. Because neither party could be certain of the rights which it had obtained or conceded, the process of negotiating an agreement would be made immeasurably more difficult by the necessity of trying to formulate contract provisions in such a way as to contain the same meaning under two or more systems of law which might someday be invoked in enforcing the contract. Once the collective bargain was made, the possibility of conflicting substantive interpretation under competing legal systems would tend to stimulate and prolong disputes as to its interpretation ... [and] might substantially impede the parties' willingness to agree to contract terms providing for final arbitral or judicial resolution of disputes.

82 S.Ct. at 577 (footnote omitted).

In subsequent decisions, the Supreme Court consistently has given broad scope to the preemptive effect of Section 301. In Allis-Chalmers Corp. v. Lueck, 471 U.S. 202, 105 S.Ct. 1904 (1985), an employee, alleging a bad faith refusal to honor his claim for disability benefits as provided by a collective bargaining agreement, sued his employer and the insurance company that administered the disability benefits. The Court reemphasized the compelling interest in uniform federal labor law underlying the doctrine of preemption:

> [Q]uestions relating to what the parties to a labor agreement agreed, and what legal consequences were intended to flow from breaches of that agreement, must be resolved by reference to uniform federal law, whether such questions arise in the context of a suit for breach of contract or in a suit alleging liability in tort. Any other result would elevate form over substance and allow the parties to evade the requirements of § 301 by relabeling their contract claims as claims for tortious breach of contract.

105 S.Ct. at 1911.

More important, the Court noted that "the need to preserve the effectiveness of arbitration was one of the central reasons that underlay the Court's holding in Lucas Flour." 105 S.Ct. at 1915. The Court explained that arbitrators, and not courts, must decide issues relating to the interpretation of collective bargaining agreements:

> A rule that permitted an individual to sidestep available grievance procedures would cause arbitration to lose most of its effectiveness, as well as eviscerate a central tenet of federal labor contract law under § 301 that it is the arbitrator, not the court, who has the responsibility to interpret the labor contract in the first instance.

Id. (citation omitted). Accordingly, the Court held that the employee's claim was preempted, since proof of bad faith would require proof of a breach of contract:

> Because the right asserted not only derives from the contract, but is defined by the contractual obligation of good faith, any attempt to assess liability here inevitably will involve contract interpretation.... These questions of contract interpretation, therefore, underlie any finding of tort liability, regardless of the fact that the state court may choose to define the tort as "independent" of any contract question. Congress has mandated that federal law govern the

> meaning given contract terms.

105 S.Ct. at 1914-5 (footnote omitted). See also Lingle v. Norge Division of Magic Chef, 486 U.S. 399, 405, 108 S.Ct. 1877, 1881 (1988)("if the resolution of a state-law claim depends upon the meaning of a collective- bargaining agreement, the application of state law ... is pre-empted and federal labor-law principles ... must be employed to resolve the dispute"); Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 23, 103 S.Ct. 2841, 2853 (1983)("the preemptive force of § 301 ... displace[s] entirely any state cause of action 'for violation of contracts between an employer and a labor organization'") (citation omitted); Turner v. AFT Local 1565, 138 F.3d 878, 884 (11th Cir. 1998)("if the resolution of a state-law claim depends upon interpreting the terms of a collective bargaining agreement, then the state-law claim is preempted by the LMRA").

Federal courts in Alabama have made clear that an employee subject to a collective bargaining agreement, such as Jordan, has no possible state law remedy for claims relating to a discharge, benefits or other rights governed by the terms of the collective bargaining agreement. For example, in Rasheed v. International Paper Co., 826 F.Supp. 1377 (S.D.Ala. 1993), plaintiff ("Rasheed"), a former employee of defendant International Paper ("IP"), asserted various claims relating to his discharge, including that IP improperly considered portions of his disciplinary history when making the decision to discharge him. In light of the fact that Rasheed was represented by a union and the terms of his employment were governed by a collective bargaining agreement, the Court dismissed the contract claim as a matter of law, concluding that the claim was preempted by the LMRA:

> [P]laintiff essentially challenges IP's action in considering a portion of plaintiff's disciplinary

> history (that is, oral reprimands) in making the decision to terminate him. The [Collective Bargaining] Agreement in this case relegated authority to IP to terminate employees for 'just cause'; IP 'policy,' however, provided for the circumstances under which disciplinary matters would be considered in making a 'just cause' determination. Even if the breach of contract claim is construed as not being 'directly founded' on the collective bargaining agreement, resolution of the claim nevertheless is 'substantially dependent' on an analysis of that Agreement. Accordingly, the claim is preempted by § 301 of the LMRA.

826 F.Supp. at 1384. Similarly, in Bolton v. McWane Cast Iron & Pipe Co., 328 F.Supp.2d 1229 (N.D.Ala. 2004), plaintiff ("Bolton") was employed by defendant McWane Cast Iron & Pipe Co. ("McWane") as a maintenance employee. As such, Bolton was part of a bargaining unit represented by a union. After Bolton was injured when he drove off the road on his way home after a 14 hour work day, he asserted a state law claim against McWane, alleging that McWane was negligent in requiring him to work 14 hours on a shift. The Court concluded that Bolton's state law claim was completely preempted by Section 301 of the LMRA, as it necessarily implicated and was dependent upon an analysis of the controlling collective bargaining agreement:

> The CBA in this case specifically addresses overtime. It provides in part, "The Company has the right to schedule overtime work for the plant, its departments and various groups of employees." (CBA at 7.) Since there is no independent state law duty available to Plaintiff, an evaluation of his claim will by necessity involve a determination of whether this provision and other provisions of the CBA imply a duty of care in scheduling overtime so as to avoid injury to employees.

328 F.Supp.2d at 1235. See Turner v. AFT Local 1565, supra, 138 F.3d at 884 ("Because

resolution of Turner's tortious interference with employment claim would require interpretation of the terms of the collective bargaining agreement, we hold that this claim is preempted by the LMRA.").

Here, Jordan's claims are unquestionably tied to, intertwined with and dependent upon an interpretation of the CBA. Article 3.3 of the CBA provides that employees, such as Jordan, may only be terminated for "just cause":

> Employees having more than ninety (90) calendar days of service may be discharged for just cause and such discharge must be by written notice to the employee stating the reason for the discharge. For the purpose of this section, "just cause" shall include but shall not be limited to: dishonesty; intoxication; violation of the Company's drug and alcohol policy; harassment policy or safety policies and procedures; assault; battery; fighting; damage or theft of property or product; and professional gambling.

Article 17 of the CBA expressly requires Equity to provide certain health insurance benefits. Moreover, Article 6.2 of the CBA contains exclusive grievance and arbitration procedures to resolve "any difference, dispute, or complaint aris[ing] over the interpretation or application of this Agreement," which are therefore directly applicable to Jordan's claims.

Accordingly, Jordan's claims are completely preempted by federal labor law. His claims, no matter how cast as for breach of contract, wrongful discharge, outrageous conduct or infliction of emotional distress, are expressly based on his termination and denial of benefits, and cannot possibly be resolved without an interpretation of the terms of the CBA. For the same reasons set forth in Rasheed v. International Paper Co., supra, and Bolton v. McWane Cast Iron & Pipe Co., supra, Jordan's claims against Equity must be dismissed. Jordan cannot avoid this result merely by creative labeling; "[t]he pre-emptive force of [Section] 301 is so powerful as to

displace entirely any state cause of action 'for violation of contracts between an employer and a labor organization.'" Caterpillar Inc. v. Williams, 482 U.S. 386, 107 S.Ct. 2425, 2430 (1987)(citation omitted).

2. Even If Jordan's Claims Were Construed As Section 301 Claims, They Must Be Dismissed.

Section 301 permits an employee to sue his employer for violations of a collective bargaining agreement only under limited circumstances. Thus, in order to bring a valid action under Section 301, an employee protected by a collective bargaining agreement must allege that (1) he has exhausted all available contractual grievance and arbitration remedies and (2) that the union has violated its duty of fair representation. Vaca v. Sipes, 386 U.S. 171, 87 S.Ct. 903, 914 (1967); Del Costello v. International Brotherhood of Teamsters, 462 U.S. 151, 103 S.Ct. 2281, 2290-1 (1983); Coppage v. United States Postal Service, 281 F.3d 1200, 1204 (11th Cir. 2002); Abrams v. Shehan, 1998 U.S.Dist.LEXIS 5318, *29 (S.D.Ala. 1998); Rasheed v. International Paper Co., supra, 826 F.Supp. at 1387. Thus, even were the Court to construe Jordan's state law claims as Section 301 claims, those claims still must be dismissed.

In fact, all of Jordan's claims, including any complaints for a discharge without just cause or regarding the termination or status of his health insurance coverage, are subject to the mandatory and exclusive grievance procedure set forth in the CBA. Clearly, Jordan has not alleged that he exhausted those procedures, including any internal union procedures for an appeal, with respect to any grievance related to the accident, his employment termination, or the termination of his health insurance benefits.

Nor has Jordan alleged that the Union breached its duty of fair representation in connection with any grievance or term of Jordan's employment. To do so, as the United States

Supreme Court has made clear, Jordan would be required to allege that the Union acted in an arbitrary or discriminatory manner, or in bad faith. Vaca v. Sipes, supra, 387 S.Ct. at 916; see also Air Line Pilots Association, International v. O'Neill, 499 U.S. 65, 111 S.Ct. 1127, 1135 (1991)("Any substantive examination of a union's performance, therefore, must be highly deferential, recognizing the wide latitude that negotiators need for the effective performance of their bargaining responsibilities.") (citations omitted). The Complaint, however, is totally bereft of even of a hint of such an allegation. This case must be dismissed.

C. Jordan's State Law Claims Related to His Loss of Health Insurance Benefits Are Also Completely Preempted by ERISA

Jordan alleges his health insurance benefits were improperly terminated in connection with the termination of his employment with Equity. [Complaint, ¶7.] The Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L No. 99-272, Title X, Section 100001(codified at 29 U.S.C. .§§ 1161 et seq.) ("COBRA"), which amended ERISA, requires sponsors of ERISA group health plans to provide the option to elect continuation coverage in certain circumstances for a limited period of time following employment termination. See 29 U.S.C. §§ 1161(a), 1162. "A claim regarding the alleged wrongful denial of benefits to a plaintiff covered under such a continuation of coverage is governed by ERISA." Mattive v. Healthsource of Savannah, Inc., 893 F.Supp. 1556 (S.D. Ga. 1996).

Jordan's claim for improper termination of health insurance benefits cannot be brought under state law because all state laws that "relate to" employee benefit plans are preempted by ERISA. 29 U.S.C § 1144(a); Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41 (1987) (bad faith and fraud claims preempted); Young v. Ramsay Youth Services of Dothan, 313 F.Supp.2d

1275 (M.D. Ala. 2004) (fraud, conversion, breach of contract, conspiracy to defraud, conspiracy to convert funds and outrage claims preempted). However, rather than pursuing remedies available under ERISA's exclusive civil enforcement scheme, Jordan seeks to recover damages under state common law theories of fraud and the tort of outrage, which are outside of ERISA's statutory framework. Plaintiff's state law claims are preempted and due to be dismissed.

In Butero v. Royal Maccabees Life Insurance Company, 174 F.3d 1207 (11th Cir. 1999), the Eleventh Circuit outlined as follows the four factors for establishing the complete preemption (or "superpreemption") of state law claims by ERISA:

> Here's the rule: ERISA superpreemption exists only when the "plaintiff is seeking relief that is available under 29 U.S.C. § 1132(a)." *Whitt*, 147 F.3d at 1330. Regardless of the merits of the plaintiff's actual claims (recast as ERISA claims), relief is available, and there is complete preemption, when four elements are satisfied. First, there must be a relevant ERISA plan. *See id.*; *Kemp v. International Business Machs. Corp.*, 109 F.3d 708, 713 (11th Cir. 1997). Second, the Plaintiff must have standing to sue under that plan. *See Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1350 n.3 (11th Cir. 1998). Third, the defendant must be an ERISA entity. *See id.*; *Franklin v. QHG of Gadsden, Inc.*, 127 F.3d 1024, 1029 (11th Cir. 1997). Finally, the complaint must seek compensatory relief akin to that available under §1132(a); often this will be a claim for benefits due under a plan. *See Engelhardt*, 139 F.3d at 1354; *Franklin*, 127 F.3d at 1029.

Butero, 174 F.3d at 1212 (citation omitted).

Each of the four Butero complete preemption factors is satisfied by the allegations asserted in the Complaint: (1) Equity's health insurance plan is an ERISA "employee welfare benefit plan" as defined by ERISA Section 3(1)(29 U.S.C. § 1002 (1)), and, pursuant to ERISA

Section 4(a) (29 U.S.C. § 1003(a)), is governed by ERISA; see summary plan description attached as Exhibit 2; (2) as a participant in the plan at the time of his termination, Jordan has standing under ERISA Section 502(a) (29 U.S.C. § 1132 (a)) to bring claims under the plan for enforcement of plan terms, enjoinment of acts or practices that violate ERISA or plan terms, equitable relief to redress ERISA violations or to enforce ERISA or plan provisions, clarification of rights to future plan benefits, and/or recovery of plan benefits; (3) Equity is an ERISA entity because it was Jordan's employer; see Morstein v. National Ins. Servs., Inc., 93 F.3d 715 (11th Cir. 1996); and (4) the damages sought are akin to those available under § 1132(a), as his Complaint explicitly seeks damages for loss of health insurance coverage; see 29 U.S.C. § 1132(a) (1)(B) (allowing a plaintiff to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan.").

Jordan's artful characterization of his damages claims, purportedly cast in terms of outrageous conduct and fraud, cannot avoid their complete preemption by ERISA and must be dismissed. See York, supra (claim seeking return of plan premiums and reimbursement for medical costs caused by lapsed coverage in addition to damages such as emotional distress is akin to relief available under 29 § 1132(a)).

Besides complete preemption under ERISA Section 502(a) (29 U.S.C. § 1132(a)), ERISA also preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA Section 514(a)(29 U.S.C. § 1144(a)). Section 514(a) is "ERISA's express preemption provision" that "defeats claims that seek relief under state-law causes of action that 'relate to' an ERISA plan." Butero v. Royal Maccabees Life Ins. Co., 174 F. 3d 1207, 1212 & 1215 (11th Cir. 1999). Claims "relate to" an ERISA plan if they have "a

connection with or reference to" an employee benefits plan. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47, 97 S. Ct. 1549, 1553, 97 L. Ed. 2d 39 (1987). See also Howard v. Parisian, 807 F.2d 1560, 1563-1564 (11th Cir. 1987) ("ERISA preempts all state laws insofar as they apply to employee benefit plans").

The Eleventh Circuit broadly interprets ERISA's expansive preemption clause. Swerhun v. Guardian Life Ins. Co. of Am., 979 F.2d 195 (11th Cir. 1992) ("ERISA is a comprehensive statute that subjects employee benefit plans to federal regulation… The Supreme Court has noted that the preemption clause 'is conspicuous for its breadth'… and has instructed that the clause should be 'expansively applied'") (citations omitted); First Nat'l Life Ins. Co. v. Sunshine-Junior Food Stores, Inc., 960 F.2d 1546, 1550 (11th Cir. 1992), *cert. denied*, 506 U.S. 1079 (1993) ("Congress used the words 'relates to' in their broad sense and did not mean to preempt only state laws specifically designed to affect employee benefit plans…A state law relates to an employee benefit plan if it 'has a connection with or reference to such a plan'") (citations omitted).[2]

State law claims such as fraud, outrage, and bad faith refusal to pay have repeatedly and unequivocally been determined to be preempted by ERISA in this Circuit. Young, supra; see also Gilbert v. Alta Health & Life Ins. Co., 276 F.3d 1292, 1299 (11th Cir. 2000) ("Alabama's

[2] See also Brown v. Connecticut Gen. Life Ins. Co., 934 F.2d 1193, 1196 (11th Cir. 1991) ("ERISA 'completely preempts' the area of employee benefits plans," therefore claims made under state law for benefits under an ERISA plan are converted to federal claims through ERISA 'super preemption') (citation omitted); Farlow v. Union Cent. Life Ins. Co., 874 F.2d 791, 794 (11th Cir. 1989) (A "state law cause of action 'relates to' an employee benefit plan if the [defendant's] conduct giving rise to such claim was not 'wholly remote in content' from the benefit plan"); Clark v. Coats & Clark, Inc., 865 F.2d 1237, 1243 (11th Cir. 1989) (ERISA preempts all state laws insofar as they "relate to" employee benefit plans, even if those laws only indirectly regulate the plans); Amos v. Blue Cross-Blue Shield of Ala.,868 F.2d 430, 431 (11th Cir. 1989), cert. denied, 493 U.S. 855, 110 S. Ct. 158 (1989) ("ERISA preemption is not a gateway but a barrier to state law causes of action, the effect of which is to completely displace state law claims."); Jackson v. Martin Marietta Corp., 805 F.2d 1498, 1499 (11th Cir. 1986) ("[S]tate laws found to be beyond the scope of § 1144(a) [ERISA's preemption clause] are few.").

tort [of] bad faith refusal to pay is not saved from preemption by ERISA's saving clause"); Walker v. Southern Co. Servs., Inc., *et al.*, 279 F. 3d 1289, 1293 (11th Cir. 2002) (same); Wilcox v. Std. Ins. Co., 340 F. Supp. 2d 1266, 1275 (N.D. Ala. 2004) (same); Engelhardt v. Paul Revere Life Ins. Co., 139 F.3d 1346, 1354 (11th Cir. 1998) (putative state law fraud claim fell within scope of ERISA and was therefore preempted); Hall v. Blue Cross/Blue Shield of Alabama, 134 F.3d 1063, 1065 (11th Cir. 1998) ("claims for fraud and misrepresentation arising out of the failure to pay plan benefits are preempted by ERISA"); Brown v. Neely Truck Line, Inc., 884 F.Supp. 1534, 1537 (M.D. Ala. 1995) (fraud claims are preempted under ERISA).

As explained in detail above, Jordan's Complaint purports to set forth causes of action pursuant to the common law of the State of Alabama. However, on the face of the complaint, these state law claims "relate to" the Plan, are preempted and barred by the provisions of ERISA. [See Complaint, ¶ 7; Count One, ¶¶ 2, 3(b)].

In addition, Jordan's claims for extracontractual damages are not permitted pursuant to ERISA. Jordan's Complaint demands judgment against Defendants in the form of unspecified compensatory damages and punitive damages to be determined by a jury. See "Wherefore" clauses at the conclusion of each count of the Complaint. Jordan's claims for extracontractual damages should be stricken from the Complaint, as such damages are not recoverable under ERISA. Godfrey v. Bellsouth Telecomm., Inc., 89 F.3d 755, 761 (11th Cir. 1996) (the District Court did not err in holding that extra-contractual damages are not available in this case; a plan beneficiary can sue to enforce her rights under the plan and under ERISA, and for equitable relief, but not for punitive or compensatory damages.); Ingersoll-Rand Co. v. McClendon, 111 S. Ct. 478 (1990); McRae v. Seafarers' Welfare Plan, 920 F.2d 819, 822-23 (11th Cir. 1991), reh'g denied, 931 F.2d 901 (11th Cir. 1991). ERISA authorizes beneficiaries to bring actions to

enforce their rights under the plan, but does not provide for any extracontractual relief, such as punitive damages. Amos v. Blue Cross-Blue Shield of Ala., 868 F.2d 430 (11th Cir.), cert. denied, 493 U.S. 855, 110 S. Ct. 158, 107 L. Ed. 2d 116 (1989); Bishop v. Osborn Transp., Inc., 838 F.2d 1173, 1174 (11th Cir.), cert. denied, 488 U.S. 832, 109 S. Ct. 90, 102 L. Ed. 2d 66 (1988).

D. Jordan's Claims Against Jennifer Baker and Randy Cline Should Be Dismissed

Jordan specifies no claims against Defendants Jennifer Baker and Randy Cline, employees of Equity. The gravamen of his Complaint is that Equity improperly terminated his employment and his health insurance benefits. Permitting a plaintiff to simply name individual employees as defendants without any stated basis violates any standard of pleading. See Butero, 174 F.3d 1207, footnote 2. Accordingly, Jordan's claims against Baker and Cline are due to be dismissed.

E. Jordan Is Not Entitled to a Jury Trial on His ERISA Claims

Finally, Jordan's Complaint includes a jury demand on all claims. [Complaint at p. 4.] The Eleventh Circuit, however, has routinely held that Plaintiffs are not entitled to a jury trial pursuant to ERISA. Stewart v. KHD Deutz of Am. Corp., 75 F.3d 1522, 1527 (11th Cir. 1996), cert. denied, 117 S. Ct. 300 (1996) (no Seventh Amendment right to a jury trial exists in actions brought pursuant to ERISA); Blake v. Unionmutual Stock Life Ins. Co. of Am., 906 F.2d 1525, 1526 (11th Cir. 1990) (holding that beneficiaries were not entitled to a jury trial on their ERISA claim for benefits under group health policy); Howard v. Parisian, Inc., 807 F.2d 1560, 1567 (11th Cir. 1987) (stating that the former Fifth Circuit squarely held that Plaintiffs in actions under 29 U.S.C. § 1132(a)(1)(B) are not entitled to a trial by jury); Chilton v. Savannah Foods &

Indus., Inc., 814 F.2d 620, 623 (11th Cir. 1987) (former employee seeking to recover benefits under ERISA was not entitled to a jury trial); East v. B.L. Long, 785 F. Supp. 941, 942 (N.D. Ala. 1992) (this court is bound to follow the current holdings of the Eleventh Circuit that Plaintiffs in ERISA cases are not entitled to trial by jury); see also Frados v. Cont'l Cas. Co., 363 F. Supp. 2d 1349, 1355 (S.D. Fla. 2005) (notwithstanding plaintiff's reference to money damages, plaintiff had no recourse to a jury under ERISA in an action seeking long-term disability benefits).

WHEREFORE, PREMISES CONSIDERED, Defendants respectfully request that this Court dismiss this case in its entirety, including Jordan's claims for extracontractual damages relating to his loss of health insurance benefits, and to strike Jordan's demand for a jury trial as to his ERISA claims.

/s/ Joel P. Smith, Jr.

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CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of March, 2008 I served the foregoing upon counsel of record for all parties to this proceeding via the Court's CM/ECF electronic filing notification system:

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